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WOUNDED WARRIOR CARE AND REINTEGRATION REQUIRES A PUBLIC-PRIVATE PARTNERSHIP

by

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A paper submitted to the Faculty of the Joint Advanced Warfighting School in partial satisfaction of the requirements of a Master of Science Degree in Joint Campaign Planning and Strategy. The contents of this paper reflect my own personal views and are not necessarily endorsed by the Joint Forces Staff College or the Department of Defense.

This paper is entirely my own work except as documented in footnotes.

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ABSTRACT

In present day combat, Improvised Explosive Devices (IEDs) and Explosively Formed Projectiles (EFPs) are the enemy's principal weapons of choice. Due to medical advances, many service men and women are alive today that normally would have expired from their injuries in the past, thus creating a greater burden on society and the government for their care. Existing infrastructure and care providers at Department of Defense and U.S. Department of Veterans Affairs hospitals are insufficient to deal with the long term inpatient care of 50,806 unpredicted wounded warriors (excluding Traumatic Brain Injury and Post Traumatic Stress Disorder numbers, which are often outpatient care; when included the numbers rise to 266,810 and 800,000 respectively). While some upgrades to existing hospitals have occurred and some new facilities have been built, the military medical system is overwhelmed. An integral part of the National Security Strategy and the moral imperative that guides this country is the obligation to assist veterans during their recovery.

Based upon the current fiscal status of the nation and sequestration, the current model is unsustainable and requires a construct that is financially supportable and leverages a public-private partnership with American society to properly care for and reintegrate wounded warriors. A public-private partnership with universities and philanthropic organizations will bring care to wounded warriors that the government is unable to provide. Furthermore, a public-private partnership with non-profit organizations will move society closer to those who serve, raising awareness and creating potential funding streams for reintegration.

This thesis advocates the need to establish a formalized public-private partnership with non-profit organizations, universities and philanthropic organizations to address the growing number of existing and returning veterans that require support services, care and reintegration. The critical nature of properly caring for returning veterans is not only an issue of moral conscience and fiscal responsibility, but one of keeping faith with those whose sacrifices sustain our way of life.

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DEDICATION

For big sisters looking out for little brothers everywhere, veterans helping other service members and veterans, our nation's wounded warriors, especially Paul.

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CHAPTER 1: INTRODUCTION

In his 1789 inaugural address, General and President George Washington stated “the willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation.”

The severity and sheer number of non-fatal injuries sustained by service members in the wars in Afghanistan and Iraq has created a requirement substantially greater than in previous wars to reintegrate survivors back into society. The long-term costs of war to society are greater because military medicine advances since 1950 have allowed larger numbers of combat wounded to survive, but not without significant disabilities. Presently, the mean financial projection of support services in the Fiscal Year 2013 budget for Department of Defense (DoD) Health Care overall is \$32.5 billion. At some point in the near future defense spending will draw down, part of an inevitable post-war adjustment, and the overall defense budget will be slashed as part of an attempt to reduce federal spending.¹ Funding for wounded warriors and for the Department of Veterans Affairs (VA) research will inevitably be affected.

Largely because of the advances in military medicine, the number of combat casualties with life changing injuries is greater than any other war in American history.² The ability or inability to care for our wounded veterans and reintegrate them into society impacts those considering service in the military. People join the military for many

¹ Roger Altman and Richard Haass, “American Profligacy and American Power,” *Foreign Affairs*, (November/December 2010), 30.

² Rich Morin, “For Many Injured Veterans, A Lifetime of Consequences.” *PEW Research Center*. PEW Research Social and Demographic Trends, Percentage of Wounded Who Survived by War Chart (November 8, 2011), 3. <http://pewrsr.ch/KyD6sf#.UON62Q5WC-s.email> (accessed January 1, 2013).

reasons: patriotism, to do their part, benefits, care for family, parents forcing children to gain maturity and discipline. Regardless of why people join the military, only 17 percent who enter remain until retirement.³ This means that new service members are continuously recruited to sustain an all-volunteer force. Communities in the United States have dealt with casualties and injuries since the Revolutionary War. After the Civil War, homes were developed for wounded Union veterans amongst other social programs designed to aid transition back into local communities. Society's reaction to returning veterans from the Civil War through World War II differed greatly from today. During this period, the principle responsibility for veterans' care was borne by the surrounding community. Small town values, stable family structures and the strength of individual patriotism dictated minimal government support, but World War II changed that due to the sheer number of returning veterans. Public sentiment to help World War II veterans return to civilian life grew. In 1930, Congress established the Veterans Administration consolidating three bureaus (the previously independent Veterans' Bureau, the Bureau of Pensions and the National Homes for Disabled) to provide for care of the nation's veterans and in 1932, the New Deal started to change care to a federal government responsibility, and the name changed from Veterans Administration to U.S. Department of Veterans Affairs in 1988.⁴ More rights were given to veterans in 1944

³ Richard Spencer, Modernizing the Military Retirement System Report FY11-05 Recommendations to Optimize the Department's Military Retirement System, Secretary of Defense, Defense Business Board Report, (Washington DC, July 2011), 3-4.

⁴ "In 1932 Franklin Delano Roosevelt was elected overwhelmingly on a campaign promising a New Deal for the American people. Roosevelt worked quickly upon his election to deliver the New Deal, an unprecedented number of reforms addressing the catastrophic effects of the Great Depression...Roosevelt felt it was the federal government's duty to help the American people weather these bad times," *Public Broadcasting System (PBS)*, "The New Deal" article, 2013, 1. <http://www.pbs.org/wgbh/americalexperience/features/general-article/dustbowl-new-deal/> (accessed May 27, 2013).

with the Servicemen's Readjustment Act, known as the GI Bill of Rights, as a result of changing public sentiment.

Until the end of the Vietnam War, the United States had a draft and veterans served in the military and returned to local communities. Veterans were visible to communities. Prior to the New Deal, veteran care was accomplished by local communities, but with the end of the draft more veteran care shifted to federal programs such as the VA. Today, many casualties with invisible wounds such as Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) are returning to society.⁵ The DoD casualty statistics for Wounded in Action since September 11, 2001 (9/11) from Operation IRAQI FREEDOM (OIF), Operation NEW DAWN (OND), and Operation ENDURING FREEDOM (OEF) is 50,806⁶ excluding casualties that "are injuries or death due to the elements, self-inflicted wounds, combat fatigue."⁷ When TBI is considered, the number is 266,810⁸ and when PTSD--also called combat fatigue--is added, the number is 800,000 troops.⁹ PTSD and TBI injuries occurred in World War II when millions served, but medical technology then could not diagnose them as well. Those injuries can be medically and scientifically diagnosed now and the treatment costs are substantial. Many veterans with catastrophic injuries are living and sustaining productive lives with fewer local support systems; the care falls to federal programs.

⁵ Terry Tanielian and Lisa Jaycox, eds., "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery," Santa Monica: *RAND Corporation*, MG-720-CCF, 2008, 1. http://www.rand.org/pubs/research_briefs/RB9336/index1.html (accessed October 1, 2012).

⁶ United States (U.S.) Department of Defense, "U.S. Casualty Status," May 28, 2013), 1. <http://www.defense.gov/news/casualty.pdf> (accessed May 28, 2013 updated from August 21, 2012 status).

⁷ U.S. Joint Chiefs of Staff, *DoD Dictionary of Military and Associated Terms*, Joint Publication 1-02, Hostile casualty definition, (Washington, DC: Director, Joint Staff, November 8, 2010 As Amended Through April 15, 2013), 128.

⁸ Defense and Veteran Brain Injury Center, "DoD Worldwide Numbers for TBI 2000-2012," Feb 13, 2013, 1. <http://www.dvbic.org/dod-worldwide-numbers-tbi> (accessed May 28, 2013).

⁹ Gregg Zoroya, "Huge Burden on Caregivers of Military Wounded," *USA Today*, March 8, 2013, 1-2. Author note: Due to differing numbers, the wounded warrior statistic used for this thesis will be 50,806.

Society's responsibility as a whole to wounded veterans must be taken up through new and innovative ways.

Although government documents including the National Security Strategy dictate the importance of veterans' programs to treat and support wounded warriors, current evidence shows there are areas that need improvement.¹⁰ The commitment as a nation to the service member does not end at their respective termination of service,¹¹ but rather continues for the duration of their lives as do the scars of the wounds they received defending the United States' great freedoms. The National Military Strategy states, "Our leaders are the strongest advocate for our Nation's commitment to caring for our wounded veterans and their families. . . . But we must balance this commitment by better managing the increased costs of health care."¹²

Even now with a defense budget that has been robust, remote Army Warrior Transition Units (WTUs are the medical facilities where wounded warriors go to receive treatment until they are returned to duty or go through a medical board) do not always have the right equipment for injured service members returning from the battlefield.¹³ The severity of some injuries is so unique that the DoD and the VA hospitals lack necessary equipment and medical specialists in some areas for specialty care.¹⁴ Each service has medical facilities and programs for wounded warriors.¹⁵ A Government Accountability Office (GAO) study notes that while the federal government and the VA

¹⁰ U.S. President. *National Security Strategy*, (Washington DC: Government Printing Office, May 2010), 14.

¹¹ Chairman of the Joint Chiefs of Staff. *National Military Strategy*, (Washington DC: Government Printing Office, May 2011), 16.

¹² *Ibid.*, 17.

¹³ Interviewee name withheld by mutual agreement. Army Wounded Warrior, interview by author, Norfolk, VA, January 3, 2013.

¹⁴ Jason Redman, interview by author, Chesapeake, VA, November 18, 2012.

¹⁵ Each Service has different wounded warrior facilities and programs that will be explained in Chapter 3.

are doing everything possible regarding wounded warrior care and reintegration, the volume and effort of care required are simply overwhelming.¹⁶ As the United States brings military operations to an end and inevitable defense spending reductions begin, an already inadequate support and treatment effort for wounded service members will face a severe crisis. The government's increasing inability to help wounded warriors over the next twenty years demands that American society assume additional responsibility for the care and reintegration of those who bear the scars of war. A public-private partnership is needed to provide the assistance for wounded warriors that the government is unable to provide. This partnership will generate and sustain funding, support reintegration, and raise awareness. A public-private partnership has the benefit of bringing society closer to those who serve.¹⁷

Although, there are several government-funded wounded warrior programs in existence, congressional testimony¹⁸ has confirmed that these programs suffer from bureaucratic mismanagement.¹⁹ "Specifically in October 2011, we [GAO] recommended that departments strengthen functional integration across all care coordination and case management programs to reduce redundancy and overlap."²⁰ The two programs specific to that report were the Federal Recovery Care Program (FRCP) and Recovery Care

¹⁶ United States Government Accountability Office (U.S. GAO), *DoD and VA Health Care: Action Needed to Strengthen Integration across Care Coordination and Case Management Programs*. Washington, DC: U.S. Government Printing Office GAO Report GAO-12-129T, 2011, 2.

¹⁷ Kristin M. Hall, "Building The Best For Injured Soldiers: Nonprofit's medical clinics focus on brain injuries, PTSD," *Washington Post*, August 22, 2012, 1.

¹⁸ U.S. GAO, *Federal Recovery Coordination Program: Enrollment, Staffing, and Care Coordination Pose Significant Challenges*, Washington, DC: U.S. Government Printing Office GAO Report GAO-11-572T, 2011, 3.

¹⁹ U.S. GAO, *DoD and VA Health Care: Action Needed to Strengthen Integration across Care Coordination and Case Management Programs*. Washington, DC: U.S. Government Printing Office GAO Report GAO-12-129T, 2011, 2.

²⁰ U.S. GAO, *Recovering Servicemembers and Veterans: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits*. Washington, DC: U.S. Government Printing Office GAO Report GAO-13-5, 2012, 49.

Program (RCP), with the main sticking point being care coordination between the VA and DoD. In November 2012, both departments agreed to take steps to better align all programs (wounded warrior programs, VA's Liaison for Healthcare Program, and VA's OEF/ OIF/ OND Care Management Programs) not just FRCP and RCP.²¹

In contrast to some of the mismanaged government-funded programs, privately-funded wounded warrior programs in existence are more consistently well-managed and have enjoyed overwhelming support by the public. A public-private partnership will assist in streamlining bureaucratic inefficiencies and improve the quality of care and reintegration at a lower cost. In the words of General Jose de San Martin in 1815 in the battle to liberate Argentina:

Let us stop being selfish. . . To the idea of the common good and our existence, everything must be sacrificed . . .the lack of funds does not even allow us to take care of the most elementary thing . . . As from today our salaries are cut in half . . . I shall measure patriotism by generosity . . . From this moment on, luxury and comforts must make us ashamed.²²

Based on the idea of the common good and patriotism, non-profit organizations and privately-funded wounded warrior programs work to give back to wounded warriors. Throughout American history, there has been a deep appreciation for the service and sacrifices made by veterans. This appreciation was fostered in the twentieth century by universal military service. Those wars were fought largely by draftees, citizen-soldiers who returned to civilian life at the expiration of their service obligation. Veterans were more visible in society and a combined sense of social responsibility and cultural benevolence provided much support. This situation changed with the post-Vietnam all-

²¹ U.S. GAO, *Recovering Servicemembers and Veterans: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits*. Washington, DC: U.S. Government Printing Office GAO Report GAO-13-5, 2012, 49.

²² Peter G. Tsouras, *Warrior's Words: A Dictionary of Military Quotations*. New York: Arms and Armour Press, 1994, 381. Quote attributed to General Jose de San Martin, 1815; quoted in 1957 by Rojas, San Martin.

volunteer force. The wars in Iraq and Afghanistan are the first to be fought under this construct. As a result, veterans are less visible in society and consequently, the sense of obligation within society has diminished. Neither DoD nor the VA anticipated the enormous burden of taking care of veterans while also fighting two wars. Unlike draftees who were mustered in and released from service en masse, volunteers are constantly joining or leaving the service, continually putting pressure on the system. Added to this is the large number of returning wounded--more individuals are surviving severe combat injuries, but the nature of these injuries require care and treatment that the government is unprepared to give. Thus, veterans are confronted with dated programs and underfunded agencies resulting in diminished quality of life standards for survivors. A 2011 GAO report advised the military and the VA to investigate the current wounded warrior and veterans' programs in order to alleviate duplication and ensure wounded warriors do not get lost in the system; however, a subsequent GAO report stated some progress had been made, but alleviating duplication had not been accomplished.²³ More progress needs to be made to avoid conflicting information between care coordinators and case managers.²⁴

To make progress in alleviating duplication and problems with care and reintegration, the Secretary of Defense, under the provisions of Section 724 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84) established the DoD Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces, better known as the Recovering Warrior Task Force whose objective is to:

²³ U.S. GAO, *DoD and VA Health Care Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges*. Washington, DC: U.S. Government Printing Office GAO Report GAO-11-250, 2011, 22-24.

²⁴ Ibid.

assess the effectiveness of the policies and programs developed and implemented by the DoD, and by each of the Military Departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces; and make recommendations for the continuous improvements of such policies and programs.²⁵

This thesis offers recommendations for improving wounded warrior care and reintegration. The financial cost to guarantee wounded warrior care, quality of life and the cost to reintegrate them into society rises each year. The current model of federal funding has proven inadequate and the need for health care and support services will continue to expand as wounded warriors age and as commitments to OEF continue.²⁶ With the backdrop of an all-volunteer force, the military's future rests with its ability to successfully recruit new service members. If American society does not have a sense of obligation to take care of the wounded veterans and their families, the nation will not be able to maintain an all-volunteer force. A public-private partnership can alleviate some of the financial costs of medical care, allowing society to meet its obligation. Successful wounded warrior reintegration will aid in limiting the psychological costs associated with illnesses like PTSD.²⁷

Documented research and case studies will show that advances in technology and medicine have had a major influence on battlefield survival, what one individual has described as "10 minutes from blast to bird."²⁸ Analysis of current veterans' programs, scientific literature, and advances in medicine and military tactics, techniques and

²⁵ U.S. Department of Defense, *Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces Chapter*. Washington, DC: Department of Defense, November 20, 2012, 1.

²⁶ Michael Tennant, "U.S. Negotiating to Keep Troops in Afghanistan Past 2014," *The New American Magazine*, October 17, 2012, under "special forces in Afghanistan through 2024," <http://www.thenewamerican.com/usnews/foreign-policy/item/13251-us-negotiating-to-keep-troops-in-afghanistan-past-2014> (accessed December 31, 2012).

²⁷ Dan Edge, "The Wounded Platoon," *Public Broadcasting System (PBS) Frontline*, 2010, 1.

²⁸ Tyler Southern, interview by author, Chesapeake, VA, December 8, 2012.

procedures will be used to validate the thesis argument. Post-war casualties and injuries from the Civil War to OEF and OIF with a focus on wounded warriors, their care givers, care providers and care representatives since 9/11 and the costs of war will be explained. Wounded warrior interviews illustrating the differences in care and examples of public and private care for Special Operations, Navy, Army, Marine, Air Force Active Duty members and Reserve Component personnel represented by Army National Guard members will be presented as three case studies. An examination and analysis of the requirements for reintegration into society will show why establishing a private-public partnership for healthcare and reintegration of wounded veterans back into society is essential. The private side of this partnership includes examples of non-profit organizations, university partnerships, and philanthropic organizations that have assisted in wounded warrior care and reintegration.

This thesis will offer recommendations and ideas gained through research for the Recovering Warrior Task Force to consider implementing to improve wounded warrior care and reintegration or for the Joining Forces Initiative to consider as challenges for the 130 schools in the university medical public-private partnership initiative announced in January 2012 to solve. Public-private partnerships broaden society's perspective of the costs of war and the public knowledge of the cost of freedom, and the thesis will close with why establishing a public- private partnership for healthcare and reintegration of wounded warriors back into society is essential.

In order to grasp the magnitude of the crisis, it is necessary to examine the impact of medical advances and adaptations in modern warfare. The next chapter, Realities of Modern Warfare, traces the evolution of warfare and medicine from the Civil War to the

present and shows how medical advances have contributed to saving many lives that might have been lost in the past.

CHAPTER 2: REALITIES OF MODERN WARFARE

Rich Morin of the PEW Research Center observes, “proportionately more soldiers now survive shattering injuries that would have killed their predecessors.”¹



Figure 1: Percentage of Wounded Who Survived by War²

Indeed, 88 percent of those wounded since 9/11 have survived, a higher percentage than any war in the history of the United States.³ During the Vietnam War,

¹ Rich Morin, “For Many Injured Veterans, A Lifetime of Consequences.” *PEW Research Center*. PEW Research Social and Demographic Trends, Percentage of Wounded Who Survived, by War Chart (November 8, 2011), 3: Post-9/11 88%, Vietnam 72%, Korea 74%, WWII 62%, WWI 64%, Civil War 44%, Mexican War 24%, War of 1812 67%, and Revolutionary War 58%. <http://pewrsr.ch/KyD6sf#.UON62Q5WC-s.email> (accessed January 1, 2013).

² Ibid.

³ Ibid.

the ratio of wounded versus fatalities was 2.6 to 1 (153,000 to ~58,000).⁴ Since September 2001 this ratio has skyrocketed to 7.8 to 1 (~50,000 to 6,400) or proportionally three times as many wounded warriors requiring care.⁵ This reality presents formidable capacity challenges for a fiscally-strapped healthcare sector already struggling to meet care demands. To better understand this new paradigm, it is important to review both the evolution of warfare and medicine and its impact.

The military historian Sir John Keegan eloquently describes the realities of the evolution of warfare: “Weapons have never been kind to human flesh, but the directing principle behind their design has usually not been that of maximizing the pain and damage they can cause. Before the invention of explosives, the limits of muscle power in itself constrained their hurtfulness,” but with time and the evolution of weapons, Keegan says, “restraints were cast to the winds, and it is now a desired effect of many man-killing weapons that they inflict wounds as terrible and terrifying as possible.”⁶

Although technology has improved weapons and the effectiveness of delivering destruction, insurgents in Iraq and Afghanistan have turned to more primitive means by perfecting the Improvised Explosive Device (IED) as the principal weapon against coalition forces. The past decade of counterinsurgency operations has seen military adaptations against an asymmetric threat in both individual and vehicular protection. The response has been a return to a medieval solution by applying armor to men and vehicles.

⁴ Allan R. Millett, Peter Maslowski and William B. Feis, *For the Common Defense: A Military History of the United States from 1607 to 201*, Free Press, 2012, 681-682.

⁵ Ibid.

⁶ Sir John Keegan, *The Face of Battle* (New York, New York: Penguin Books, 1976), 329.

Evolution of Medicine and Medical Evacuation

In addition to added protection, advances in medical capabilities have improved battlefield survival. Effective debridement of wounds, use of intravenous fluids and whole blood to resuscitate wounded soldiers were used in World War I. Medical advances in World War II led to fewer soldiers dying from infection, the overwhelming cause of death in armies before antibiotics.

Peripheral vascular surgery was performed in the Korean War for the first time, which dropped the amputation rate for brachial wounds from 35 percent to zero and for femoral wounds from 61 percent to 4.8 percent.⁷ Other medical innovations during the Korean War included the use of intravenous solutions such as plasma and blood, clotting defect recognition, and hypertensive shock documentation.⁸ Treatment of battle fatigue also changed in the Korean War from World War II by treating people on the front lines with rest, then returning them to duty.

Battlefield medicine and surgery significantly improved in the Vietnam War. The impact of the ability to stop bleeding within fifteen seconds and advances in vascular surgery allowed more amputees to survive. As one observer has noted, military medicine in Vietnam was characterized as “helicopter evacuation, more rapid resuscitation, and readily available specialty surgery.”⁹

The advances in Vietnam and treating infection did not just occur overnight. Medical advances during the Vietnam conflict were the culmination of a century of progress in treating trauma and controlling infectious diseases. Additionally the nature of the conflict engendered a unique spectrum of psychiatric, medical, and traumatic problems.¹⁰

⁷ Harry G. Summers, Jr., *Korean War Almanac*. Facts on File, Inc. New York 1990, 183. Brachial plexus is the nerve network that runs from the spinal cord in the neck and shoulder all the way to the hands. Femoral wounds are injuries to the groin, body cavity and upper-leg-complicated if femoral artery is struck.

⁸ Ibid.

⁹ Spencer C. Tucker, editor, portion written by Jack McCallum. *Encyclopedia of the Vietnam War A Political, Social, and Military History Volume One*. ABC-CLIO, Inc. 1998, 423.

¹⁰ Ibid.

Due to medical advances and response time, many combat wounded survive that would have died previously. The increase in survival rates has resulted in the overburdening of an already stressed military medical system; this is why wounded warrior care is an issue for society. “Perhaps the greatest lifesaver was not a medical innovation at all but a transportation innovation: the use of aircraft for medical evacuation. Studies during WWI had shown that there was a direct relationship between the hours that elapsed between severe wounding and treatment, and the mortality rate.”¹¹

In World War I and World War II medical evacuation (medevac) was accomplished by hand-carried litter and ambulance, which often took twelve to fifteen hours.¹² Medical care and evacuation improved from World War II to the Korean War in part because it was the first time helicopters were used extensively to evacuate wounded from the battlefield, cutting the time to 4 to 6 hours.¹³ General-use helicopters were used for medevac in the Korean War, but the U.S. Army Medical Department air ambulance units were used from April 1962 on.¹⁴ Medevac flights able to land practically anywhere “provided rapid response and reduced time from injury to treatment” which “helped reduce the ‘deaths to percentage of hits’ rate from 29.3 percent in World War II and 26.3 percent in Korea to 19 percent in Vietnam.”¹⁵ Mobile Army Surgical Hospitals (MASH) were used in Korea and Vietnam. Not only have immediate life-saving measures been significantly improved over U.S. history, but advanced life-saving facilities are now placed well forward in the combat zone.

¹¹ Summers, 183.

¹² Ibid.

¹³ Ibid.

¹⁴ Tucker, 420.

¹⁵ Ibid. ‘Deaths to percentage of hits’ rate can be explained as service members were shot but not as many deaths occurred by bullets fired as were shot due to flight time getting them to a medical facility rapidly to keep them from expiring from their wounds.

Medevac methods and shortened response times have played a significant role in saving lives. The first hour after a life-threatening injury is described as the “golden hour”: if the wounded individual is treated within that hour, he has a higher chance of survival. Building on the MASH units of the Korean and Vietnam Wars, Level II medical facilities in both the Iraq and Afghanistan campaigns were predicated on adhering to this dictum. In cases of severe life-threatening injuries, responding within the “platinum 10 minutes” can be the difference in life or death. In the OEF campaign, United States Marine Corps (USMC) Corporal (Retired) Tyler Southern is living proof of what air medevac can do in a case of the platinum 10 minutes “from blast to bird.”¹⁶ Corporal Southern stepped on a ten-pound IED during a patrol in Afghanistan on May 5, 2010. Southern explained, “Ten pounds could take out a house. While the Navy corpsman worked on me, my squad leader called in a perfect nine-line MEDEVAC [medical evacuation request] and the helicopter arrived within 10 minutes.”¹⁷

Corporal Southern further explained the impact of battlefield medicine and medevac on his experience:

I was told I flat-lined three times in the first 24 minutes. Usually someone who flat-lines three times dies. The corpsman said I stopped breathing 10 times in Forward Support Base Bastion [a British Forward Operating Base in Afghanistan], but they were able to resuscitate me each time. I was given 20 units of blood. My lateral was gone, trajectory of my right eye was off (it is good now--just have a scar over my right eye after the surgery). I have British blood in me from Bastion. The Captain said I bled out three times and they ran out of American blood, so they had to use British blood. My lungs collapsed. They put bone wax in my cranium for the flight not to crush my brain from Afghanistan to America. They thought I was going to die after all that and they wanted me to die on American soil, and not in Afghanistan. Medevac is one of the key reasons I made it, but also the corpsman and doctors knowing and doing their jobs. Blast to Bethesda was four days.¹⁸

¹⁶ Tyler Southern interview.

¹⁷ Ibid. Author note: A nine-line MEDEVAC request is a report to higher headquarters called in over the radio to request a helicopter evacuation of a casualty that could result in loss of life, limb or eyesight.

¹⁸ Tyler Southern interview.

The medical improvements made in Vietnam have been built upon in the wars in Iraq and Afghanistan as illustrated by Corporal Southern's medevac experience. Other innovations besides medevac have occurred in modern military warfare. Air Force Surgeon General Lieutenant General (Dr.) C. Bruce Green and Command Surgeon Colonel (Dr.) Mark Mavity of Air Force Central Command were interviewed by reporters at a Military Health System Conference in Washington, DC on February 1, 2012, and spoke of five innovations in modern warfare military medicine: aerovac [aeromedical evacuation], size of hospitals (smaller than those in Operation DESERT STORM in 1991 because of aerovac), critical-care air transport teams, better tents for expeditionary medical support system, and electronic records from medics in the field to surgeons.¹⁹ Passing electronic records from field medics to surgeons is completed on a system called the Composite Health Care System that makes a patient's entire medical history available at the point of treatment. Aerovac, critical-care air transport teams and electronic records transfer from medics in the field to surgeons all aided in Corporal Southern's immediate battlefield to hospital care and recovery and for other wounded warriors whose stories will be told in the next chapter. Another thing Corporal Southern has in common with all of the other wounded warriors interviewed is PTSD.

PTSD and TBI

Psychiatric disease has had many names over the course of warfare. Shell shock in World War I became known as war neurosis, battle fatigue and combat fatigue in World War II; after Vietnam in 1980, it became known as PTSD. Battlefield casualties for shell shock in World War I were twenty to thirty percent of battlefield casualties and

¹⁹ Jill Laster, "Military Medicine," *Air Force Times*, February 13, 2012, 3.

applied to “an assortment of symptoms including anxiety, an exaggerated startle response, tremors, nightmares, hallucinations, delusions, withdrawal, and catatonia.”²⁰

Shell shock was also known as neurasthenia and war neurosis.

Post-war treatment of veterans diagnosed with shell shock, neurasthenia or war neurosis was a difficult and expensive problem facing the nation. “In the United States as late as 1940, 27 of 90 veterans hospitals were designated as psychiatric facilities and treatment of shell shock victims had cost in excess of \$1 billion.”²¹

Shell shock was a difficult and expensive problem facing the nation after World War I, and PTSD is still a difficult and expensive problem facing the nation as OEF continues. PTSD is an anxiety disorder that results from exposure to at least one traumatic event which resulted in injury or the threat of injury or death. PTSD provokes fear, helplessness or horror in response to threat of injury or death. There are several ways those that suffer PTSD experience the disorder. Three common ways are hyperarousal which can lead to insomnia, avoidance of things that remind the person about the traumatic event (e.g. fireworks), or re-experiencing the event which can occur in nightmares.²² PTSD in Iraq is reported at 4.5 percent for those not directly involved in a firefight and at 19.3 percent in those involved in five or more engagements.²³ Another injury that can sometimes be associated with PTSD is Traumatic Brain Injury (TBI),

²⁰ Jack E. McCallum, *Military Medicine From Ancient Times to the 21st Century*. ABC-CLIO, INC., 2008, 294.

²¹ *Ibid.*, 296.

²² Jason Redman interview.

²³ McCallum, 249.

which military medicine now understands better. “TBI and PTSD are the signature wounds of Operation Enduring Freedom and Operation Iraqi Freedom.”²⁴

Between January 2000 and December 2012, 266,810 service members have received TBI diagnoses.²⁵ TBI, according to the Center for Disease Control and Prevention, “is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.”²⁶ Not every blow or jolt to the head results in a TBI. Concussions are not always considered a TBI, although exposure to repeated blasts or “concussive events” can create problems.²⁷

TBI can sometimes be associated with PTSD because some of the symptoms are common. This makes diagnosis and treatment difficult. “A TBI-related event can also be a trauma leading to PTSD.”²⁸ The Navy and Marine Corps have publicly stated concern over TBI: “The high rate of TBI and blast-related concussion events resulting from current combat operations directly impacts the health and safety of individual service members and, subsequently, the level of unit readiness and troop retention.”²⁹ All of the Services understand the severity of TBI and its impact on the Services. There are multiple programs in the Defense Centers of Excellence working on standardization of care for TBI and the relationship of TBI to PTSD.

²⁴ Terry Tanielian and Lisa Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica: RAND Corporation, MG-720-CCF, 2008, 1. http://www.rand.org/pubs/research_briefs/RB9336/index1.html (accessed October 1, 2012).

²⁵ Defense and Veteran Brain Injury Center, “DoD Worldwide Numbers for TBI 2000-2012,” Feb 13, 2013, 1. <http://www.dvbic.org/dod-worldwide-numbers-tbi> (accessed May 28, 2013).

²⁶ Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, “An Executive Level Overview of Psychological Health and Traumatic Brain Injury in the Defense Department: Understanding the Facts and Recognizing the Misconceptions”, 2012, 2.

²⁷ Ibid.

²⁸ Ibid., 6.

²⁹ Headquarters USMC Division Public Affairs, *Division of Public Affairs Current News Playbook*, Media Team, October 3, 2012, 81.

A study done by the RAND Corporation, titled *Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans*, examined three major battlefield conditions: PTSD, major depression, and TBI. The study concluded that “unlike physical wounds, these conditions affect mood, thoughts, and behavior and often remain invisible to other service members, family, and society” and the study further notes “fundamental gaps remain in our understanding of the mental health and cognitive needs of U.S. service members returning from Afghanistan and Iraq, the costs of mental health and cognitive conditions, and the care systems available to deliver treatment.”³⁰

The USAF wounded warrior interviewed for this thesis served with the Navy, USMC, and USAF, and has experience with AF medical processes and in USSOCOM medical operations. He served three joint SOF combat deployments and one additional deployment embedded with the Army as a combat advisor in Afghanistan. He was Air Force Special Operations Command Medical Service Officer of the Year in 2005 and 2006, and his unit was recognized as the USAF Flight Medical Team of the Year in 2007. This background is provided to prove his credibility to speak to the medical recognition and diagnosis of TBI:

There is lag time between increased residual effects explosive yields/IEDs/asymmetric warfare and the medical recognition/diagnosis of those effects. There were some patient regulating/tracking and post-injury care measures we were able to implement within the DoD system to aid with that.³¹

The increased residual effects of explosive yields of IEDs and the medical recognition and diagnosis of those effects the USAF wounded warrior discusses are gaps in our understanding and knowledge in the RAND study mentions. The full impact of the effects of explosive yields of a TBI on wounded warriors remains to be seen and studied.

³⁰ Tanielian and Jaycox, 1.

³¹ Ibid.

To provide a frame of reference for the number of those diagnosed: the number of wounded warrior injuries excluding combat fatigue/PTSD is 50,806,³² with TBI is 266,810,³³ and with PTSD is 800,000.³⁴ Wounded warrior, PTSD, and TBI numbers will not be final until all forces have returned from OEF, and barriers to care discussed in the next part of this chapter mean there are more wounded warriors that have not yet been diagnosed as not everyone who has PTSD reports having or suffering from it. The follow-on moral costs to society have been studied at Fort Carson, Colorado, in the *Public Broadcasting System (PBS) Frontline* episode “Wounded Platoon,” but have yet to be seen for the nation as a whole.³⁵ The Wounded Platoon refers to 36 members of the same unit at Fort Carson, Colorado, that have killed themselves since serving multiple tours in OIF and fourteen Fort Carson soldiers have been charged or convicted in 13 murders and manslaughters in the last five years.³⁶ The type of fighting environment led not only to increases in PTSD, but also outright fatalities due to a soldier’s inability to maintain a keen fighting attitude over such long periods. The treatment system is overwhelmed with 50,806 wounded warriors for inpatient care. With 266,810 to 800,000 that researchers have said have suffered TBI and PTSD, the lack of trained care professionals and the toll on caregivers are issues for society. The wounded warrior caregiver story impacts more of society than the Army, Marine, Navy and Air Force Wounded Warriors caregivers interviewed for this thesis. A RAND study titled *Huge Burden on Caregivers of Military Wounded* stated, “from 275,000 to 1.1 million

³² U.S. Department of Defense, “U.S. Casualty Status,” May 28, 2013, 1.

<http://www.defense.gov/news/casualty.pdf> (accessed May 28, 2013, updated from previous status) .

³³ Defense and Veteran Brain Injury Center, “DoD Worldwide Numbers for TBI 2000-2012,” Feb 13, 2013, 1. <http://www.dvbic.org/dod-worldwide-numbers-tbi> (accessed updated information May 28, 2013).

³⁴ Gregg Zoroya, “Huge Burden on Caregivers of Military Wounded,” USA Today, 8 March 2013, 1-2.

³⁵ Dan Edge, “The Wounded Platoon,” *PBS Frontline*, 2010, 1.

<http://www.pbs.org/wgbh/pages/frontline/woundedplatoon/etc/script.html> (accessed August 22, 2012).

³⁶ Ibid.

Americans are caring in their homes for relatives and wounded” and “it’s taking a toll on them directly and that is an unseen cost of war.”³⁷ Chapter 3 will provide further insight into the unseen costs of war by explaining effects on the family of being a caregiver for a wounded warrior.

There are different ways to treat PTSD: psychotherapy (also known as counseling) and pharmacotherapy (also known as anti-depressant medicine) are two of them. According to research presented at the “Invisible Wounds: Military Management of PTSD” panel hosted by Old Dominion University’s (ODU) Department of Philosophy and Religious Studies’ Institute for Ethics and Public Affairs February 21, 2013, these two treatments have shown improvement in thirty to fifty percent of PTSD cases.

“Unless treated, PTSD, depression, and TBI can have far-reaching and damaging consequences. Individuals afflicted with these conditions face higher risks for other psychological problems and for attempting suicide.”³⁸

The key findings of the RAND Corporation Invisible Wounds Study are that 31.5 percent of returning service members report having either a mental health issue or report experiencing a TBI; of that 31.5 percent, seven percent meet criteria for a mental health problem and also report a possible TBI.³⁹ Diagnosing PTSD and TBI can be difficult as the two conditions share some common symptoms. The research presented at the ODU PTSD panel also showed common comorbidities between TBI, depression, sleep disturbance, chronic pain, and increased morbidity making the RAND study consistent with other PTSD and TBI research. In addition to the RAND study and research presented at the ODU PTSD panel, anecdotal evidence suggests that PTSD and TBI are

³⁷ Gregg Zoroya, “Huge Burden on Caregivers of Military Wounded,” USA Today, 8 March 2013, 1-2.

³⁸ Tanielian and Jaycox, 3.

³⁹ Ibid., 3.

not always reported. The reasons why they are not reported are explained by an Army wounded warrior:

Mental health has a stigma in the Army. Alpha males make up infantry units; if you say you are having post-traumatic stress, people think less of you. We don't want to fail our buddies. If you are taken off a mission, you feel like you failed your buddies. I am an infantry team leader, so me being out if I report post-traumatic stress, plus two guys to watch me means less sleep for all of us. We do what we have to do to get through the mission and I'd be more of a burden on them if I say something.⁴⁰

In addition to the stigma associated with PTSD in the military, the RAND study offers five additional reasons for avoiding treatment illustrated in Figure 2.

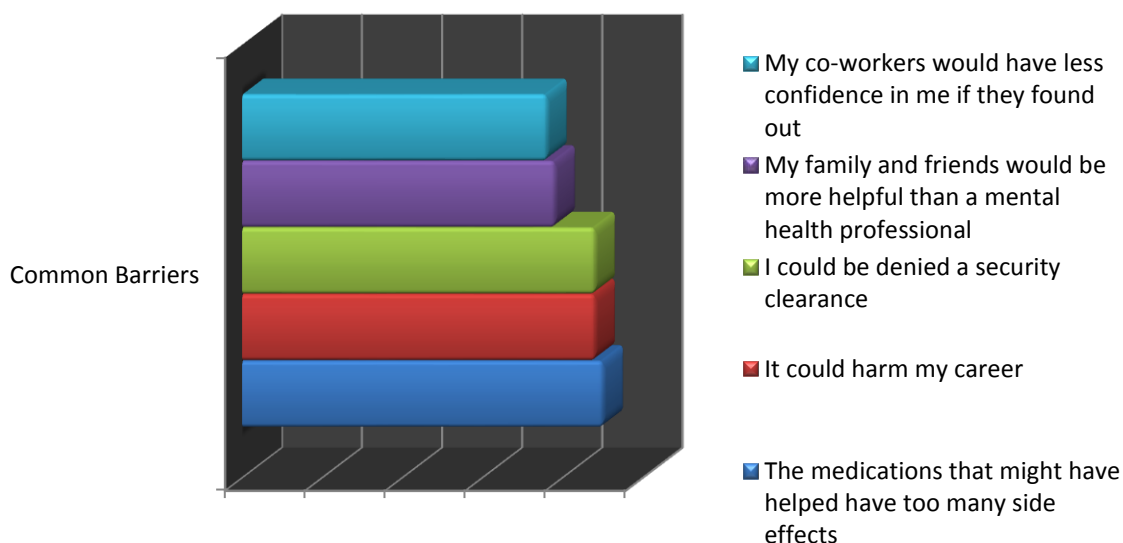


Figure 2: Top Five Barriers to Seeking Mental Health Care Chart⁴¹

Due to the stigma associated with seeking care and fear of seeking care harming one's career, not all who need the care seek it. There is a warrior ethos in the military that one does not want to be a burden on their unit. Continued efforts by the military to seek care and return to duty should be sustained. The barriers to care in Figure 2 are

⁴⁰ Army Wounded Warrior interview.

⁴¹ Tanielian and Jaycox, 3. My co-workers would have less confidence in me if they found out 38%; My family and friends would be more helpful than a mental health professional 39%; I could be denied a security clearance 44%; It could harm my career 44%; The medications that might have helped have too many side effects 45%.

reasons why military members and veterans will not seek care at a younger age but later in life, those reasons go away and veterans age 55-65 may seek care. In a VA Vocational Rehabilitation and Employment (VR&E) Program review, GAO found that most users of the VR&E Independent Living track were Vietnam era veterans in their 50s or 60s with the most prevalent disabilities of PTSD and tinnitus at \$6,000 cost per veteran for 182 cases equaling \$14 million.⁴² Those suffering from PTSD who do not seek care now have the potential to seek treatment in their 50s or 60s.

There are additional barriers to those who do seek treatment for PTSD. “The greatest challenge for many returning veterans is not just dealing with PTSD but also trying to manage their suffering while striving for a normative life in American society...trying to create a ‘successful’ life.”⁴³ In addition to dealing with PTSD and trying to be successful in life, there are scheduling delays for those who seek care and the quality of care is uneven. “Significant improvements in the quality of care the VA provides for depression have been documented, but efforts to evaluate the quality of care provided within the VA for PTSD remain under way.”⁴⁴

The DoD and VA are doing all they can to care for those with PTSD and TBI, but the RAND Corporation Study reveals:

There is substantial unmet need among returning service members for care of PTSD and major depression. DoD, the VA, and providers in the civilian sector need greater capacity to provide treatment, which will require new programs to recruit and train more providers throughout the U.S. health care system.⁴⁵

⁴² U.S. GAO, *VA Vocational Rehabilitation and Employment Program: Improved Oversight of Independent Living Services and Support is Needed*. Washington, DC: U.S. Government Printing Office GAO Report GAO-13-474 Highlights, 2013, 1.

⁴³ Dr. Erin P. Finley, “Fields of Combat: Understanding PTSD Among Veterans of Iraq and Afghanistan,” Cornell University/ILR, 2011, 10.

⁴⁴ Tanielian and Jaycox, 3.

⁴⁵ *Ibid.*, 4.

The shortage of care providers mentioned in the RAND study relates to PTSD problems and realities of modern war. In addition to the shortage of care providers, there are shortages in specialists. A case where the right specialist was not on staff occurred at the Patriot Inn, an inpatient treatment center for wounded Marines at Naval Medical Center Portsmouth. The Patriot Inn has amputees but no amputee prosthetic adjuster, so wounded warriors are sent to Tidewater Prosthetics. Having an amputee adjuster to conduct prosthetic adjustments or a timely appointment for an adjustment would have saved a Marine another surgery. A Marine did not get an appointment for an adjustment in the private sector in a timely fashion, leading to an infection of the remaining portion of his amputated leg and a subsequent surgery to amputate more of the limb. More prosthetic adjusters are needed, as well as care providers. More care providers to provide better care would make a difference in separation or retention in the military as the Marine in this case chose to separate due to this incident. The United States has dealt with post-war casualties and injuries since its inception, but the number of post-war injuries has never been such a high percentage of those who served (due in part to not fully understanding PTSD in the past).

CHAPTER 3: ISSUES FOR SOCIETY

Post-war Casualties and Injuries

War is an interesting thing on the human body. With war you are on an emotional high paying attention to everything on the battlefield and all the parts of the mission. Suddenly and immediately, you are taken out of the battle and you're struggling with a lot of things, with what you've done, be it that you are a young infantry guy or a seasoned warrior and have spent half your life in the service, and you ask yourself where do I go from here? You are lying in a hospital bed in pain and on drugs wondering where does my life move forward to? That's coupled with all the complex decisions you have to make. With minor trauma, it is easier to patch you up and send you on your way to heal up, but when you are talking about loss of limbs or massive trauma, the doctors have to figure out how to put you back together.¹

While on a mission to capture a high value individual in Iraq in 2007, Lieutenant (LT) Jason "Jay" Redman, United States Navy SEAL, was shot twice in the left arm, then while putting on his own tourniquet, was shot in the jaw which exited through his nose and nasal cavity. He took more rounds to his Kevlar helmet, body armor, weapon and night vision goggles. He was medically evacuated to Baghdad, then Balad Air Base, then Landstuhl Regional Medical Center in Germany, to Bethesda Naval Medical Center; and after five weeks, he was sent back to his parent command. Being shot multiple times brings life-changing injuries for wounded warriors.

This chapter uses three case studies to explain the U.S. military wounded warrior medical systems and reasons why wounded warrior care and reintegration are issues for society. The first case study continues LT Redman's story to explain how the Special Operations Community cares for its wounded warriors; the second case study focuses on the Active Duty component through USMC and United States Air Force (USAF) examples; and the third case study focuses on an Army National Guard Infantryman to explain the differences in care for the Reserve Component. In all case studies, issues for

¹ Jason Redman, interview by author, Chesapeake, VA, November 18, 2012.

society that can be addressed to improve wounded care and reintegration are included. “Beyond the ‘immediate’ costs of war lay the ‘consequential’ costs--psychological as well as material or demographic--arising from war’s impact on civilian economic and social life.”²

Post-war communities in the United States have dealt with casualties and injuries since the Revolutionary War. To better understand the present, one needs to look back to the past when the executive branch established wounded warrior care. In his second inaugural address, President Lincoln called upon the Congress “to care for him who shall have borne the battle and for his widow, and his orphan,”³ which was later adopted as the VA motto and carried over to the Department of Veterans Affairs when the name changed in 1988. Caring for the United States’ wounded warriors is highlighted in the National Security Strategy.⁴ President Obama’s January 2012 State of the Union Address stated that “our freedom endures because of the men and women in uniform who defend it. As they come home, we must serve them as well as they’ve served us.”⁵

The primary responsibility for veterans’ care fell on the surrounding community, augmented by the government. Since the establishment of the New Deal and World War II, it has been less a community’s responsibility and more of a federal responsibility to care for veterans. A reason society viewed veterans post-World War II differently was that “the scale of the sacrifice was indeed unprecedented, and this had a major impact on

² John Landers, “The Destructiveness of Pre-Industrial Warfare: Political and Technological Determinants,” *Journal of Peace Research*, Vol. 42, No. 4 Special Issue on the Demography of Conflict and Violence (July 2005), 455.

³ Department of Veterans Affairs, *VA History in Brief* (Washington, DC: U.S. Government Printing Office 2005), 5.

⁴ U.S. President. *National Security Strategy*, (Washington, DC: U.S. Government Printing Office, 2010), 14.

⁵ The White House Office of the Press Secretary. *Remarks by the President in State of the Union Address*, (Washington DC: Office of the Press Secretary, January 24, 2012), 8. <http://www.whitehouse.gov/the-press-office/2012/01/24/remarks-president-state-union-address> (accessed January 25, 2013).

society, with the loss of so many sons, husbands, and fathers. Furthermore, there were large numbers of wounded. The impact was felt in family economies and the general economy, and in private and public senses of grief.”⁶ The VA responded to this post-World War II view with “the Disabled Veterans’ Rehabilitation Act of 1943 [which] established a vocational rehabilitation program for disabled veterans who served after December 6, 1941. The VA provided 621,000 veterans with job training.”⁷ Amputees received artificial limbs after Congress authorized the VA to fill this need. As a result, the VA became a world leader in prosthetics.

Vietnam brought more survivors, but the short time between combat and returning to civilian life brought with it culture shock that caused veterans adjustment difficulties. “The anti-war climate at home also presented special readjustment problems for returning veterans. Many veterans reported feeling isolated and alienated from their peers and society in general.”⁸

While public sentiment supported veterans benefits after World War II, public sentiment changed after 1967 during the Vietnam War. Congress reenacted some of the education benefits taken away during the Korean War, and in 1971 passed the Veterans Mortgage Life Insurance program for severely disabled veterans to pay for housing modifications. Throughout all wars, society can recognize the physical scars of wounded veterans, but society cannot recognize the invisible wounds such as PTSD and TBI, conditions that have become prominent in the last decade of war.

⁶ Jeremy Black, *The Age of Total War*, Westport, CT: Praeger Security International, 2010, 98.

⁷ Department of Veterans Affairs, *VA History in Brief* (Washington, DC: U.S. Government Printing Office 2005), 13.

⁸ *Ibid.*, 18.

Today, each Service has medical facilities and programs for wounded warriors. The Army has two wounded warrior brigades, 15 battalions, 12 separate companies, and 9 Community Based Warrior Transition Units (CBWTUs) in locations where the Army does not have bases. The Marine Corps Wounded Warrior Regiment is headquartered at Quantico, VA, with two wounded warrior battalions at Camp Lejeune, NC, and Camp Pendleton, CA, plus multiple detachments. The Navy and Coast Guard wounded go to Bethesda, MD, or San Diego, CA, depending on their parent unit location, then to their parent units, and both Services receive additional aid through Navy Safe Harbor. The Air Force utilizes the Air Force Wounded Warrior Program.

Just as there are differences in different types of wounded warrior medical facilities (e.g., a wounded warrior regiment or warrior transition unit), the quality of care injured servicemen receive given unique aspects of the wars since 9/11 can be different whether a wounded warrior is injured on Active Duty (Active Component) or in the National Guard or Reserves (Reserve Component). The differences in care also depend on the resources available to the unit the wounded warrior is assigned to, whether that be the facility, the number of care providers at the facility, or the specialty of the care providers. The United States Special Operations Command (USSOCOM) Care Coalition model provides the wounded warrior a USSOCOM Care Coalition Advocate from the day of injury throughout the treatment process, the board process to return to duty or transition to the VA, and after transitioning out of the service for life.⁹ If the wounded warriors in the conventional force had the same model with the same liaison from the day of injury throughout the treatment, board, VA process, and after they transition out of the

⁹ At the time of the interview in August 2012, USSOCOM Care Coalition Representative was called a Representative but the title has changed to Advocate; therefore, all references are changed in this thesis unless used in a direct quote.

Service, it would improve the continuum of care. The Marines have a program similar to the USSOCOM Care Coalition Advocate called the Recovery Care Coordinator (RCC).

While on Active Duty, the Marine wounded warrior regiments, battalions and detachments use RCCs to coordinate care for wounded warriors; and after leaving the Service, the wounded warriors transition to the District Injured Support Cell (DISC) Program. DISC is a program that still falls under the Wounded Warrior Regiment and it helps wounded Marines after “release from active duty, assists with reintegration, education, benefits and local governmental and non-governmental and veterans’ organizations;”¹⁰ but the Marine wounded warrior transitions from an Active Duty RCC for care coordination to a DISC point of contact for care coordination.

The Navy and Coast Guard have a program called the Navy Safe Harbor Non-Medical Care Manager (NMCM) for non-medical care of wounded warriors while on active duty that extends beyond separation as well. “Navy Safe Harbor extends support beyond separation or retirement from service through the Anchor Program, a partnership with the Navy Reserve and retired members to provide mentor support during reintegration to the community.”¹¹

Army Wounded Warriors have an Army Wounded Warrior (AW2) Program Advocate and the USAF has the USAF Wounded Warrior Programs. The requirements for being assigned to a wounded warrior unit follow:

Recovery Care Coordinators, Navy Safe Harbor Non-Medical Care Managers and Army Wounded Warrior (AW2) Advocates are typically assigned to seriously wounded, ill, or injured Service members whose medical conditions are expected to last at least 180 days. Federal Recovery Coordinators (FRC) are assigned to members whose medical

¹⁰ U.S. Department of Defense, *DoD Compensation and Benefits Handbook for Wounded, Ill and Injured Service Members*, October 2011, 2.

¹¹ *Ibid.*, 3.

conditions are expected to result in their separation from active duty. Their goals are the same: to help you get the right care and support from the right people at the right time.¹²

The Air Force Wounded Warrior (AFW2) Program provides:

individualized personal support to Airmen with a combat/hostile-related illness or injury requiring long-term care. The Air Force's goal is to retain highly skilled men and women on active duty. If retention is not possible, the AFW2 Program will ensure Wounded Warriors and their families receive the full range of transition assistance.¹³

Out of all the wounded warrior programs, the USSOCOM Care Coalition

Advocate remains the same for life which enhances care coordination for the wounded warrior:

The USSOCOM Care Coalition's mission is to provide Special Operations Forces (SOF) warriors and their families a model advocacy program in order to enhance their quality of life and strengthen the overall readiness of special operations. Central to this mission is comprehensive non-medical recovery services for SOF wounded, ill or injured warriors and their families. The Care Coalition provides a system of support and advocacy to guide and assist SOF warriors and family or designated caregivers through treatment, rehabilitation, return to duty, or military retirement and transition into the civilian community.¹⁴

Given that combat injuries since 9/11 are more life changing, there are greater challenges for care. Wounded warrior care and reintegration are issues for society for the following reasons: multiple injuries, both visible and invisible life-changing types of injuries; the treatment costs for life-long care, TBI, and PTSD; rising healthcare costs; consequential costs to society (psychological and moral costs of war); a lack of trained care professionals; communication issues between multiple doctors working on a wounded warrior; and, wounded warrior care system tracking between hospitals and medical records transfer from one treatment facility to the next. Additional issues include: wounded warrior disability claims are affected by the VA record backlog of Iraq

¹² *DoD Compensation and Benefits Handbook for Wounded, Ill and Injured Service Members*, 1.

¹³ *Ibid.*, 3.

¹⁴ United States Special Operations Command (USSOCOM) Care Coalition website: <http://www.socom.mil/Care%20Coalition/Default.aspx> (accessed March 16, 2013).

and Afghanistan veterans because the DoD and VA have combined the disability rating process into the Integrated Disability Evaluation System (IDES) (there is no longer a separate DoD rating system); disparity in the disability rating assigned in the IDES process; wounded warriors going from hero status in a hospital to reality when reintegrating once home; continuum of care between Active Duty or Reserve Component to the VA; and, the toll on caregivers.

Wounded warrior care providers (doctors) and USSOCOM Care Coalition Advocates shared that since 9/11 the injuries most commonly seen by all care providers are TBI, amputations, multiple fractures, burns, and PTSD. According to a Naval Special Warfare (NSW) family services program manager:

TBI occurs from almost every blast and every fall, but unless it's bad, operators move on and won't know the impact until later on. We're also seeing hearing loss in firefights that isn't reported until later. PTSD is the condition that seems to be hiding in the dark for some.¹⁵

Steps are being taken by leadership at the highest level of USSOCOM and the Services to address the stigma associated with coming forward about having PTSD. PTSD affects wounded warriors who are serving in the military and those that separate. This is why reintegration of veterans and understanding PTSD are issues for society.

Special operators and conventional forces alike have wounded with TBI and PTSD. The impact of TBI will not be fully known until after further study of the brain's reaction to trauma over time. A wounded warrior care provider from the Naval Medical

¹⁵ The name of this interviewee is withheld by mutual agreement. Interview with a Naval Special Warfare Family Service Program Manager, interview by author, Virginia Beach, VA, August 23, 2012.

Center Portsmouth found that “Dealing with the side effects of brain injuries is something we didn’t deal with as much before 9/11.”¹⁶

Care providers interviewed proceed to explain the challenges facing wounded warriors when transitioning into society. Care providers stated that the most common challenge for wounded warriors that occur during reintegration into society are associated with memory problems from TBI or PTSD. An active duty wounded warrior care provider further explains the challenges:

Dealing with memory problems, the coordination of services, and dealing with mostly short-term memory loss. They forget to show up for appointments or they forget they’ve seen you already. If they forget about an appointment in my clinic, there is a grace period. A lot of Army people will drive from the Fort Eustis Warrior Transition Unit to aquatic therapy at Portsmouth because if they forget an appointment, there is a grace period.¹⁷

As noted in Chapter 2, the challenges for wounded warriors can be overcome with the good care providers. The cost of care is an issue for society. There is a lack of trained professionals to treat wounded warriors with TBI and PTSD and there are not enough hospitals and resources.¹⁸ A lot of one-on-one time is required and due to understaffing; wounded warriors are not getting the care they need.¹⁹ A lack of trained professionals to treat PTSD and TBI make untreated PTSD and TBI an issue for society due to crime that can stem from the associated psychological problems, domestic violence when someone with PTSD overreacts, and when those dealing with multiple TBIs or those dealing with constant pain attempt suicide. More care trained professionals for psychology and psychiatry are required.

¹⁶ The name of this interviewee is withheld by mutual agreement. Interview with a Naval Medical Center Portsmouth care provider, interview by author, Naval Air Station Oceana, January 4, 2013.

¹⁷ Naval Medical Center Portsmouth care provider interview.

¹⁸ The name of this interviewee is withheld by mutual agreement. Interview with a Special Operations Command Care Coalition Advocate, interview by author, Virginia Beach, VA, August 23, 2012.

¹⁹ Naval Medical Center Portsmouth care provider interview.

The NSW family services program manager added, “Congress can set aside the resources for the military, but the military is not obligated to take care of you at the same level as in society [time allotted for tests to diagnose TBI and PTSD]. To break that down to the individual, it means the patient will get a half hour for care when they may need four hours of care.”²⁰

The Diagnostic and Statistical Manual of Mental Disorders test used to diagnose PTSD must be completed by a mental health professional. For many veterans, there is neither the time available to diagnose PTSD, nor sufficiently trained professionals to make the diagnosis, which are contributing factors to the lack of care for PTSD.

Another issue for society is the transfer of wounded warrior medical records from one military treatment facility (MTF) to the next.²¹ Issues with referrals that result in wounded warriors and their records not making the transfer from one MTF to the next are referrals expiring or referrals being entered incorrectly by doctors (e.g. the referral is for a psychiatrist, not a psychologist) requiring reentry.²² A related problem is wounded warrior medical record transfer from DoD to the VA.

Part of the solution to the transfer in care is the wounded warrior being vigilant in working through the different hospital systems to keep referrals from expiring. Referrals must be entered correctly by doctors to improve wounded warrior care and this would alleviate getting lost in the system. Electronically transferring the wounded warrior’s medical record from DoD to DoD facility and from DoD to the VA would save time and make the care process easier once the physical evaluation board takes place and to improve transfer time between the two types of facilities. A vestibular program care

²⁰ Naval Special Warfare Family Service Program Manager interview.

²¹ Naval Medical Center Portsmouth care provider interview.

²² Naval Special Warfare Family Service Program Manager interview.

provider explained that the electronic wounded warrior medical record tracking issue, is an issue for wounded warriors and all veterans. A GAO report in 2007 gave DoD and the VA an electronic record directive stating that DoD shall pass records electronically to the VA. “The agency has spent four years and \$537 million on a new computer system, 97 percent of veterans’ claims are still filed on paper. The average wait to begin receiving disability compensation and other benefits is 273 days, and up to 327 days for veterans making claims for the first time.”²³ While progress has been made and millions of dollars have been spent, an electronic record system is not in place at all VA and DoD hospitals.

Disability Rating System

A new electronic claim filing platform has been developed to establish disability claims folders electronically and convert existing paper files to digits. “New web-accessible software has rules-based calculators to ensure consistency across the enterprise and improve quality and timeliness. The VA is currently deploying these changes to 16 regional offices and is scheduled to fully transform all 56 offices to its new operating model in 2013.”²⁴ Wounded warrior claims are affected by the VA record backlog of Iraq and Afghanistan veterans because the DoD and VA have integrated the disability rating evaluation process. The desired outcome of combining the DoD and VA disability system was to close the gap that often occurred between separation from active duty and receipt of VA benefits and compensation. Allowing Vietnam veterans to readjudicate Agent Orange exposure and Operation DESERT STORM veterans to file Gulf War

²³ Andrew Rosenthal, “The Grim Backlog at Veterans Affairs,” *New York Times*, March 11, 2013, 1.

²⁴ Allison A. Hickey, VA Under Secretary for Benefits, “Rising Tide of VA Disability Compensation Claims Prompts Major Transformation,” *Echoes Retired Army Newsletter* September-December 2012, 3.

Syndrome disability claims has increased the backlog from over 500,000 (a claim is considered backlogged at 125 days) to nearly 900,000 claims.²⁵

The disability claim and electronic record process are tied together because the medical records are required to file a disability claim. The DoD and the VA lack true interoperability between the electronic health records systems of each organization for the seamless exchange of electronic health records for wounded warrior care and the broader force. With only 16 of 56 VA offices having the same software,²⁶ a public-private partnership would improve this situation by allowing VA volunteers to speed the transition process to enter electronic records and enable the electronic system to work more quickly increasing efficiency and saving time.

Another disconnect regarding wounded warrior care is the disparity in the disability rating system. “One VA disability rater will rate someone at 40 percent, and another rater may rate someone at 100 percent for the same issue. The raters are not doctors and a medical background is not a given. Each rater interprets records differently,”²⁷ explains the USSOCOM Care Coalition Advocate.

VA raters are given a training block of instruction and a scale defining what percentage should be assigned to an injury. Repetitive injuries or injuries limiting range of motion will be assigned a higher disability percentage. The interview with the USSOCOM Care Coalition Advocate was not the first time the disparity in disability ratings was mentioned. Disability rating disparity occurred repeatedly in non-profit organization research conducted and in wounded warrior case studies. The disability

²⁵ Allison A. Hickey, VA Under Secretary for Benefits, “Rising Tide of VA Disability Compensation Claims Prompts Major Transformation,” *Echoes Retired Army Newsletter* September-December 2012, 3.

²⁶ *Ibid.*

²⁷ Special Operations Command Care Coalition Advocate interview.

rating disparity and medical boards has been reported and an appeals process exists in each Service and the VA to address disability rating disparity.

To address the wounded warrior medical board and VA disability rating system disparity issue, DoD established a pilot program in 2007 to combine the DoD medical evaluation board and VA disability rating process. The pilot program was successful and the DoD medical board/physical evaluation board system is now integrated with the VA disability rating process referred to as the Integrated Disability Evaluation System (IDES) for all Services. The Figure 3 chart provides the IDES process steps with the estimated number of days for each step for a total 295 IDES day goal for each wounded warrior.

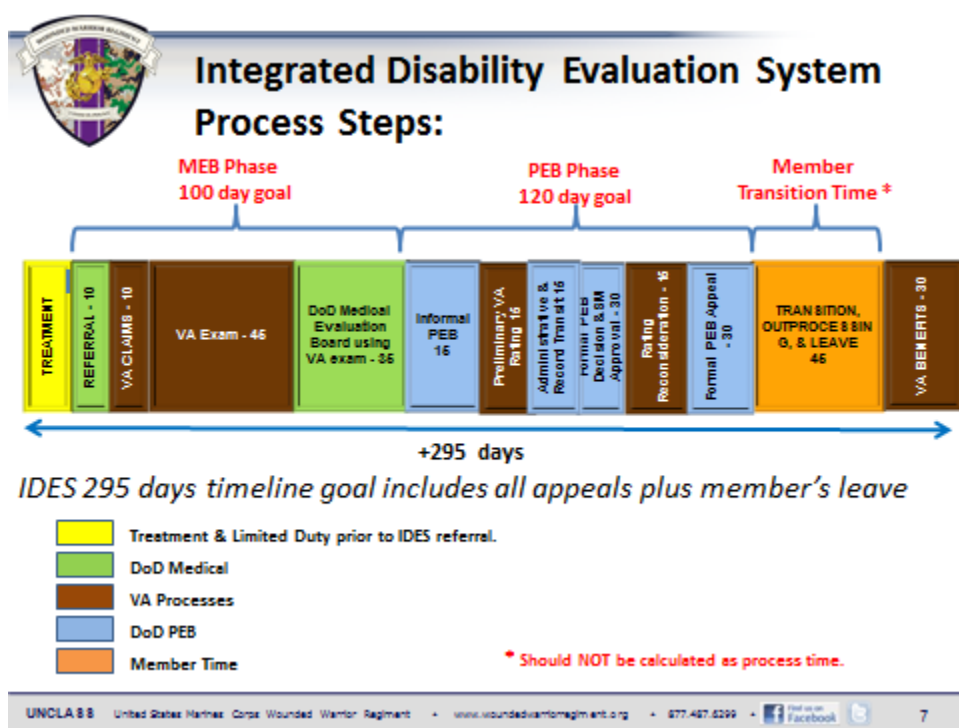


Figure 3: Integrated Disability Evaluation System Process²⁸

²⁸ United States Marine Corps Judge Advocate Division Legal Assistance Branch (JAL), “Integrated Disability Evaluation System Process”, April 2012, 1.
<http://www.hqmc.marines.mil/Portals/135/Docs/JAL/Overview%20IDES%20Apr%2012.pdf>
 (accessed March 10, 2013).

One combined system to decide the disability rating for both DoD and the VA saves time and resources (people it took to conduct two boards). There used to be a separate DoD Physical Evaluation Board (PEB). If the soldier was determined by the PEB to not be fit for duty, then the soldier was medically retired or received a stipend for the disability if it was less than 30 percent. Once terminal leave was over, the soldier could file a disability claim through the VA system. The soldier's medical record was then reviewed by the VA in a separate process. The medical board disability rating is no longer done by DoD and the VA; only the VA does disability ratings now, so this is why it affects wounded warriors. There are a limited number of VA raters for veterans and now wounded warriors are part of that population. The VA adds the disabilities up to determine a person's overall rating. The wounded warrior disability rating is based off their medical record and the narrative summary written by the doctor. There are a limited number of doctors qualified to write the narrative summaries, so if they go on leave or get deployed, it slows down the system.²⁹

To combat the disparity in disability rating errors brought up by multiple care providers and wounded warriors, a public-private partnership non-profit organization was created by two former Judge Advocate Generals (JAGs) turned law professors. The College of William and Mary Law School's Lewis B. Puller Jr. Veterans Benefits Clinic has the mission of helping military members or veterans going through the medical board process with filing claims for disability by annotating all the disability claims in a person's medical record and narrative summary before the record goes to the IDES Board. Because all disability claims the wounded warrior is seeking have been

²⁹ Special Operations Command Care Coalition Advocate interview.

researched and annotated, it saves times for the VA disability raters. There are fourteen law school students working on fifty cases this semester for wounded warriors and veterans. With this review process, there are fewer appeals to the IDES board on disparity between the injury and disability rating, combined ratings, as well as other problems with ratings. For the veterans and wounded warriors the clinic assisted with disability rating claims, the average claim rating increased 26.25 percent. The clinic legal services offered to wounded warriors and veterans from 2011-2012 would have cost \$428,325 if they had not been done by a non-profit organization.³⁰ The success of the public-private partnership of the College of William and Mary Lewis B. Puller Jr. Clinic should be built upon throughout other law schools in the nation as a solution for improving wounded warrior care and reintegration by removing disparity in the disability rating system and helping to decrease the time it takes for the VA to rate disability claims.

Wounded Warrior and Wounded Warrior Spouse Interviews

You go from hero status in a WTU [Warrior Transition Unit] or hospital to reality when you are dropped off at home. You get everything medically cleared, and all the benevolence stops. Doctors and nurses are not waiting on you hand and foot. Once you've gone through the medical board, it's up to your family or caregiver.³¹

The government can help prepare wounded warriors for reintegration, but it takes a partnership with society to bring society closer to those who serve. As part of research for this thesis, wounded warriors, caregivers, and care providers were asked how to bring society closer to those who serve and how to make society more aware of the nations' wounded and their recovery. Unique circumstances surround every wounded warrior

³⁰ Adjunct Professor of Law and Managing Attorney Stacey-Rae Simcox, Esq., The Lewis B. Puller Jr. Veteran Benefit Clinic, William & Mary School of Law, phone interview by author, January 14, 2013.

³¹ Special Operations Command Care Coalition Advocate interview.

since 9/11 in dealing with their wounds. They have dealt with the effects of what they saw, what happened to them, and what they went through. Some people struggle with PTSD while others have been treated and moved on. Some will not go back to a doctor after their experience because life changing injuries affect people differently.

With the complex decisions that have to be made on reconstructing wounded warriors, one has to balance the risk versus benefit of what to reconstruct first. In the Special Operations community and illustrated in the first case study, the command supports the operator in getting the care they need. LT Redman's team doctor was present to coordinate with the Bethesda doctors on what part of him should be reconstructed first. This type of support from the parent command in the SOF community is indicative of the community as a whole: whatever care is necessary to return the operator to duty will be done.

While the challenges each wounded warrior faces are different, so is the process of care. There were doctors who were good at explaining what procedures were going to entail and who made the wounded warrior's family comfortable about those procedures, but there were others who did not. Jay Redman compares the complex mission of putting him back together to the complex mission of Operation EAGLE CLAW (the hostage rescue attempt in Iran in 1980):

Some doctors were better than others. Some doctors expect you to take them at their word, and expect you to say, Doc, you are the SME [Subject Matter Expert], roger that--run forward and do it, but I always tried to correlate everything to my job. If you were a hostage and I was coming in to take you out of that situation, you'd say, check, roger; just take me out of here, but I wasn't a very good patient because I questioned everything. I wanted to know why they were doing something, so I asked a lot of questions to understand why. When they were talking about what they were going to do to initially reconstruct my nose, there was an intern and he would come in with literature and explain it to me. He spent hours explaining the procedures of what they were going to do and I loved it. It was great, he made things better. Some doctors are not that way and didn't explain things like that. We ended up buying books to try to understand the things they were going to do and how it was going to work.

Facial reconstruction was a complex case. It's like a very complex mission with all kinds of parts to that mission. If you think about Operation EAGLE CLAW, the mission had to be built step upon step; then think about how that mission failed. They had to fly around the world, land at a forward, in-extremis landing zone that they created, and the accident occurred. Putting me back together again was like that mission, and it was not just one step, it had to be done incrementally step upon step."³²

Jay Redman describing the hours the intern spent explaining reconstruction of his nose goes back to the time allotted for care that all wounded warrior care providers and care representatives discussed. Reconstructing someone's nose and nasal cavity is not something that can be done in a half hour block of time nor can explaining it be done in a half hour.

For Jay's wife and caregiver, Erica Redman, the type of challenges Jay's injuries brought, in addition to dealing with PTSD as a family, are that he will be life-long prone to infection and he will have to have an elbow replacement at some point.³³ Jay Redman experienced a MRSA (Methicillin-Resistant Staphylococcus Aureus) infection in his nose after one of the surgeries and the infection was extreme. He was treated in a hyperbaric chamber (used in the SEAL diving community to decompress someone if he experiences the decompression sickness after diving) because the exposure to oxygen sped up the healing process.

The problems Jay encountered with steps in his nasal and orbital reconstruction not being completed in the proper order at Bethesda could have been alleviated by plastic surgeons for his nose and face, but Bethesda did not have them on staff. A public-private partnership could have helped by getting those types of doctors involved in the care process earlier. Since being wounded in 2007, Jay has had 37 surgeries. If the right kind of specialist had been involved from the beginning of the reconstruction of Jay's nose, his

³² Jason Redman interview.

³³ Erica Redman, interview by author, Chesapeake, VA, October 2, 2012.

first nose surgery may have been the only one required; however, due to steps missed in the first surgery, two more were required. Less surgeries means less pain for the wounded warrior, less money the Services would have spent on wounded warrior care, and more resources available to care for others.

For the first several weeks and months after Jay was wounded, Erica Redman, his wife and caregiver, was overwhelmed with who does what and who was responsible for what.³⁴ As discussed by Jay, he did not have just one doctor. He had medical teams assigned to him for all of the different injuries. Erica took people's business cards and started making a notebook of who was assigned to what injury. Erica received a phone call from the command ombudsman, a USSOCOM Care Coalition Advocate calling and confirming info:

Is this the guy who is going to take me to see my husband? He was part of the SOCOM Care Coalition. I can't imagine what it would've been like if I hadn't had them. They took me to see Jay. Jay had an oral and maxillofacial surgeon for his jaw, nose, eye and face, an orthopedic surgeon for his arm, general surgery for his stomach and tracheotomy, so there were three sets of medical people. There was a head doctor and also interns. Most of the time, I saw them as three separate teams and they were not communicating with each other.³⁵

While Jay received the top battlefield medical care that can be provided and top notch care through Iraq, when he got to Bethesda there was not a plastic surgeon or Ear, Nose and Throat doctor involved in rebuilding the orbital floor of his eye (the exit wound of the bullet to the head removed his nose and destroyed his nasal cavity damaging the bottom part of his eye socket).³⁶ Jay and Erica Redman were assigned to a SOF command that backed them in getting Jay the care he needed at Bethesda and in the civilian sector. Jay was allowed to leave the military medical system to get specialty care

³⁴ Erica Redman interview.

³⁵ Ibid.

³⁶ Ibid.

in the civilian sector which was not available in the military sector. A public-private partnership does exist between TRICARE, the military health care system, and civilian doctors through a referral system, but it is not working in every wounded warrior case.

After what the Redman family endured with Jay's severe life-changing injury and recovery process, they decided they wanted to help other wounded warriors and caregivers and founded Wounded Wear, a non-profit organization, which is an example of a public-private partnership to improve wounded warrior reintegration. Jay is also a peer mentor to other wounded warriors. One of the wounded warriors with whom Jay and Erica Redman shared their lessons learned of the medical and recovery process, through Wounded Wear, was USMC Corporal (Retired) Tyler Southern.

The experience of Corporal Southern, introduced in Chapter 2, is the second case study and serves to illustrate examples of wounded warrior care from the Active Component not from the SOF community. Those Active Duty members interviewed portray that if a wounded warrior's leadership is supportive of them, the wounded warrior will receive the care that he or she requires. In addition to Corporal Southern's USMC wounded warrior story, a USAF wounded warrior's story will be combined for this case study.

Corporal Southern, whose life was saved in part by being transported from "blast to bird" in 10 minutes and by the care provided by his corpsman and doctors, stated, "I don't remember anything from the day it happened--May 5, 2010. I was in a medical induced coma to heal until May 18th at Bethesda and then had outpatient care at Walter Reed. I had a Marine Liaison Recovery Care Coordinator who arranged appointments."³⁷

³⁷ Tyler Southern, interview by author, Chesapeake, VA, December 8, 2012.

When asked about the quality of care he received given his life changing injury, Tyler Southern responded, “The best I could get. I’m still here. I had the most involved parents. My mom was a nurse and knew the medical questions to ask and my dad was military.”³⁸ Through the Long Term Disability Act, Tyler’s parents were able to take off work and be present during the initial time he spent at Bethesda.

Corporal Southern talks about what it was like when he woke up at Bethesda:

I was a gym-rat for years and had good balance which improved my adaptability for prosthetic limbs. I was raised never to dwell on the bad, always find the silver lining. I never had a problem moving on, that’s what you do. Crying about it won’t grow anything back, so I might as well move forward, put a smile on and deal with it. It’s a lot easier to handle life by laughing about it. Staying upbeat was the biggest factor in moving on in my life.³⁹

Ashley Southern, Tyler’s wife and caregiver, talks further about the challenges life-changing injuries bring to a family:

In the beginning, I had to do everything, whether that be bathing, bathroom, or getting dressed--it’s not something every girlfriend [married later] or spouse expects to do, but it wasn’t a problem. It was something I had to do. It’s kind of different when I have to help my husband put his legs on each day. It’s not a thing most wives ever think could happen.⁴⁰

Tyler Southern was hit by an IED in May 2010, and the couple started dating in September 2010. They were high school friends who reconnected when Tyler went home to see his family and friends for the first time after the injury. Ashley moved from Florida to Quantico, Virginia, to be Tyler’s non-medical attendant so his dad could go home and return to work. One of the biggest challenges for Ashley was the fact that nurses were not around anymore: “At this point, there were no doctors, no nurses unless

³⁸ Tyler Southern interview.

³⁹ Ibid.

⁴⁰ Ashley Southern, interview by author, Chesapeake, VA, December 8, 2012, interview 5.

you have an appointment. So everything is on you [the wounded warrior] and your caregiver at that point to include all the activities of daily living.”⁴¹

Ashley was in school studying to be a nurse. She gave up her career dream of being a nurse to be Tyler’s caregiver. Through Special Compensation for Assistance with Activities of Daily Living (SCAADL) authorized by the Fiscal Year 2010 National Defense Authorization Act, Ashley receives monthly compensation to be Corporal Southern’s caregiver, but it does not equal what her salary would have been upon completion of nursing school; however for her, the choice was clear.⁴²

Tyler and Ashley Southern made it through the challenges of him being a quad amputee to him functioning as independently as he could with the one arm and three fingers that were salvaged by taking his lateral muscle from the side of the lost arm and Ashley making up the difference. One advantage that Tyler had going for him in the care process was that his father was retired military and his mother was a nurse, so they knew the military medical system and were able to get Tyler the care he needed when he needed it. Tyler’s attitude also helped get him through the challenges as well. Tyler and Ashley were guided through things they were not sure about in the care process by Jay and Erica Redman, whom they met through a Wounded Wear clothing kit distribution. In addition to assistance from Wounded Wear, Tyler also received assistance from the Semper Fi Foundation, and the building of a house adaptable for his wounds was made possible by a public-private non-profit partnership with Homes for our Troops.⁴³

⁴¹ Ashley Southern interview.

⁴² Ibid.

⁴³ The Semper Fi Foundation serves the needs of severely wounded Marines and their families in honor of Lance Corporal Joshua Corral, USMC, who lost his life while serving in combat in Afghanistan; Homes for our Troops builds specially-adapted homes for service members returning home with serious injuries to

While many non-profit organizations assist wounded warriors, the Services do as well. The USAF wounded warrior who shared his experience on active duty said, “the Air Force Wounded Warrior Office are amazing people that do everything they can to assist us Wounded Warriors from MEDEVAC to the morgue.”⁴⁴

While care might be different for each wounded warrior, daily experiences are similar. One of the challenges the AF wounded warrior faces is that after the work day, “I’m pretty worn out (frankly, ‘completely smoked’) every weekday.”⁴⁵ He reflects on the struggle to get through wound recovery and rehabilitation, and discusses why it is an issue for society: “Desperation, hopelessness, and the fear of no job are issues that wounded warriors have that are common with society. Last month the Army suffered its worst month of suicides.”⁴⁶

The USAF wounded warrior worked at the Pentagon before he moved to his home of record to be closer to his family support network. He enjoyed the job in Washington, DC, but he could not drive, so he and his service dog rode in with a co-worker. The strain of the commute, the work day with TBI, and the energy it drained from him took a toll on his family. He subsequently got a job closer to his home of record where his extended family could help his wife care for him and four children.

The USAF wounded warrior’s anecdotal evidence is provided as an example of a larger issue of the toll on caregivers. A RAND study on caregivers was funded by Caring for Military Families: The Elizabeth Dole Foundation. “From 275,000 to more than 1.1

allow them to live in an environment that provides maximum freedom of movement and the ability to live more independently.

⁴⁴ Interviewee name withheld by mutual agreement. Air Force Wounded Warrior, email to author, September 18, 2012.

⁴⁵ Ibid.

⁴⁶ Ibid.

million Americans are caring in their homes for relatives wounded or emotionally damaged in the Iraq and Afghanistan wars” and “there is no national strategy for (their) caregivers,” says Dole.⁴⁷ “We’ve got to raise awareness because most Americans are not aware of these hidden heroes,” Dole adds.⁴⁸ The caregiver study is an example of a public-private partnership to be emulated to address the toll on wounded warrior caregivers and other recommendations in this thesis.

The third case study is of an Army National Guardsman wounded in Afghanistan. This example shows how difficult it is to get medical care in the National Guard and Reserve Component. His command was not supportive of a second medical opinion. This Army wounded warrior was a gunner on a convoy injured by an explosively formed projectile (EFP) blast on November 27, 2011, in Afghanistan. He was not treated on-site by a medic because his company commander left the site of the EFP and took the medic with him. He sought medical attention for injuries other than PTSD in country, but not PTSD as he did not want to “hurt” his fellow infantrymen. His story was used in Chapter 2 as anecdotal evidence for why service members do not seek care for PTSD. Although the Army wounded warrior said he was injured by the EFP blast, a medical clinic with the right equipment to treat his injuries was not located at his base. The doctor at the base said he did not have a TBI because his Kevlar was not ruined, and his company commander refused to let him go to a different base for care.⁴⁹ This case study illustrates that if the command does not support the warrior, the wound goes untreated.

⁴⁷ Gregg Zoroya. “Study: Huge Burden on Caregivers of Military Wounded,” USA Today.com, March 6, 2013, 2.

⁴⁸ Ibid.

⁴⁹ Interviewee name withheld by mutual agreement. Army Wounded Warrior, interview by author, Norfolk, VA, January 3, 2013.

On January 2, 2012, six weeks after being injured by the EFP blast, the Army Guardsman was seen by a doctor during his post-deployment health assessment at a National Guard Community Based Warrior Transition Unit (CBWTU) in Indiana and diagnosed with a fractured sacrum, crushed L5 disc, ruptured L4 disc, deviated tailbone, TBI, and torn rotator cuff. He received care for PTSD, but had to be moved to the Fort Eustis WTU to be treated for the other injuries and TBI because they did not have the equipment to treat him at the remote CBWTU location.⁵⁰ He received Magnetic Resonance Imaging (MRI) in February 2012 at the Fort Eustis WTU, which showed that he still had residual fluid on his brain from the EFP blast in November 2011. His company commander was fired once he reached the Fort Eustis WTU and the story of him not receiving medical care in country was brought to light, but his entire National Guard unit alienated him after that.⁵¹ A public-private partnership in this situation would have allowed the Army wounded warrior to leave the CBWTU to seek care in the private sector at the time of the post-deployment health assessment.

This Army wounded warrior's anecdotal evidence shows the need for doctors being forward-based with infantry units, but also shows that while the medical system is overburdened, it is not all on the medical system--leaders must be held responsible. Appropriate medical equipment is available at Level 2 facilities in Afghanistan, but those bases do not always align with locations where forward infantry units operate. Without commanders who are willing to send soldiers to a different facility for care, this type of incident could reoccur. Wounded warrior care is a leadership issue in allowing soldiers to be allowed to seek care. The top levels of military leadership speak to keeping the

⁵⁰ Army Wounded Warrior interview.

⁵¹ Ibid.

faith and taking care of wounded warriors, but that commitment has to transcend through the levels of leadership down to the company level, not just for severely wounded but for those with invisible wounds of TBI and PTSD too. Keeping the faith cannot be a hollow promise. There must be better access to care for wounded warriors to keep down the long-term costs of care and consequential costs to society.

The Cost

The cost of freedom and war is high. The cost of war is not just in treasure from the American taxpayer, but also in blood of the American soldier, sailor, airmen and marine and the “cost in human lives,”⁵² which is not just lives lost, but lives damaged. The costs of war and consequential costs are further explained by John Landers:

The costs of raising, equipping, and fielding troops loom large in histories of early-modern (and subsequent) public finance, but are only one part of the total costs of war imposed on men and women who lived through it. Costs arise wherever something valued is destroyed, lost or otherwise foregone.⁵³

What is certain is that “the consequential costs are born by the civilian population.”⁵⁴ This was true in pre-industrial warfare and remains in modern warfare, and why it is an issue for society today. To delve further into the financial costs, military personnel (pay and healthcare) and wounded warrior care accounts have been exempted from the effects of sequestration for the Fiscal Year (FY) 13 budget, but will be factored into reductions from FY14 forward. FY13 reduction to federal accounts will be \$109.33 billion, with \$54.67 billion coming from the DoD budget. With personnel accounts

⁵² Douglas B. Bamforth, “Indigenous People, Indigenous Violence: Pre-contact Warfare on the North American Great Plains,” *Man*, New Series, Vol. 29, No. 1 (March 1994), 112.

⁵³ John Landers, “The Destructiveness of Pre-Industrial Warfare: Political and Technological Determinants,” *Journal of Peace Research*, Vol. 42, No. 4 Special Issue on the Demography of Conflict and Violence (July 2005), 455.

⁵⁴ *Ibid.*, 465.

exempted, all other accounts including Procurement; Research, Development, Test and Evaluation (RDT&E); and Operations & Maintenance will be decreased by a factor greater than 10 percent to make up for the 10 percent not cut in military personnel and wounded warrior care lines. The FY13 budget report specifically states cuts to RDT&E include twelve Defense Health Programs line items including wounded warrior care research and development totaling \$7,180,300.⁵⁵ While wounded warrior care was not cut, wounded warrior research and development has already been cut due to sequestration.

Rising healthcare costs have a negative impact up and down the line, whether it is through DoD, the VA, or private sector. Financial costs for caring for 50,000 wounded warriors will rise; but there are more than financial costs; there are consequential costs which include long term requirements for care, and the psychological and moral costs of war. Only 2.2 million--less than one percent of the U.S. population of 309 million--are serving in the military⁵⁶ and only 23.5 million--eight percent of the population--have served in the military,⁵⁷ leaving, other than family members, 91 percent of the U.S. population and society disconnected from war or what it means to serve; however, the cost of war matters to the rest of society as all veterans return to society. The VA may not be able to match cost and servicing of the one percent in the military in the future, but we are obligated as a nation to support the wounded veterans according to the National

⁵⁵ Guy Eastman, "Sequestration and FY13 U.S. DoD Budget," *Jane's IHS*, August 27, 2012, 5-8.

⁵⁶ National Public Radio (NPR), "By the Numbers: Today's Military," NPR, <http://www.npr.org/2011/07/03/137536111/by-the-numbers-todays-military>, July 3, 2011. Article written in 2011; as of 2013, the U.S. population is 315 million (U.S. Census Bureau) (accessed May 28, 2013).

⁵⁷ Office of the Actuary, Veteran Population Projections Model (VetPop2011), Table 1L, U.S. Department of Veterans Affairs, http://www.va.gov/vetdata/docs/QuickFacts/Population_slideshow.pdf (accessed January 2, 2013).

Security Strategy.⁵⁸ This is the reason private-public partnership for care and reintegration is required and why it is an issue for society.

The treatment costs of TBI and PTSD are so high that they are an issue for society. The RAND report on psychological health “suggests that there is significant duplication of effort, both within and across branches of service. Without a centralized evidence base, we remain uncertain as a nation about which approaches work, which are ineffective, and which are--despite the best intent of their originators--harmful to service members and their families.”⁵⁹

Sharing treatment information across the Services, combined with evaluation on TBI care and PTSD care can help alleviate problems with care that can turn into consequential costs to society.⁶⁰ The consequential costs that are issues for society are impaired relationships, disrupted marriages, difficulties of parenting that cause problems in children, and homelessness (homelessness often comes from not being able to find a job or hold down a job due to PTSD); and “damaging consequences from lack of treatment or under-treatment suggest that those afflicted, as well as society at large, stand to gain substantially if more have access to effective care.”⁶¹

Now that post-war issues for society have been identified, such as costs, treatment, and reintegration into society of wounded warriors, ways to cut the costs for care and improve reintegration into society will be examined. One of the most significant ways is through public-private partnerships with non-profit organizations, universities

⁵⁸ U.S. President. *National Security Strategy* (Washington DC: Government Printing Office, 2010), 14.

⁵⁹ Tanielian and Jaycox, 73.

⁶⁰ Ibid., 73.

⁶¹ Ibid., 73.

and philanthropic organizations. Examples of each type of these partnerships will be discussed in the next chapter.

CHAPTER 4: PUBLIC-PRIVATE PARTNERSHIPS

Wounded Warrior Private Care Examples

The challenges wounded warriors face finding a job after their transition, looking for a way to support their families, and struggling to get through wound recovery, are broader than just a job and go to the core of who they are as a person. The wounded warrior needs a purpose, a mission after the military. As discussed earlier by Jay Redman, the challenges faced are what to focus on next and what one's purpose in life is.¹

For public-private partnerships, wounded warriors care experiences who received military and civilian care will be shared. Non-profit organization partnerships, university partnerships and philanthropic partnerships will be offered as examples of public-private partnerships that can be replicated outside of Virginia, Florida, and Texas to other states to improve wounded warrior care and reintegration.

The first wounded warrior case study in this thesis whose care was provided by a public-private partnership is Jason "Jay" Redman, U.S. Navy SEAL. As previously mentioned, Jay had complications from an Ear, Nose and Throat (ENT) doctor not being involved in reconstructing his nose or orbital floor. His jaw, nose and orbital floor were all initially reconstructed by an oral maxillofacial surgeon. Because there were issues with total nasal reconstruction in the military sector, Jay used the TRICARE option of a second opinion in the private sector:

I think we need to have a much tighter relationship with the civilian medical sector. The military has some fantastic doctors, but in very specialized care, when

¹ Jason Redman, interview by author, Chesapeake, VA, November 18, 2012.

you get into very traumatic injuries as in my case for instance, for total nasal reconstruction, there are only a few doctors in the world that do that. As opposed to the military, they do super high level specialty care and they do it all the time.²

A public-private partnership can help with access to care in a timely fashion once the wounded warrior is in the United States through a registry of care providers willing to do philanthropic work or as part of a university medical center conducting research in conjunction with DoD medical facilities. Jay is thankful for the military medical care he received on the battlefield, in country and at Bethesda:

When I talk about this, there are some fantastic military doctors and fantastic military professionals at the top of their game, but there are just as many that are not. We have the best facilities and our medical care is some of the best in the country. If they can stabilize you, they want to get you back to the States. Because I was wounded on a Thursday and they stabilized me quickly, they flew me home on the Sunday medevac. I was shot at around 0330-0400 on Thursday and was back to Bethesda by 11:00 Sunday night.³

Medical evacuation was a factor in Jay surviving his injury as it was for Tyler Southern. That part of military medicine is second to none. Two issues with military care where Jay believes a closer relationship between the military and civilian medical sectors would be beneficial fall into medical procedures and costs areas. First, military doctors should not be pushed to do procedures they may not be qualified to perform (refer those to the private sector) such as skin graft procedures:

One of my problems with the military medical system is that some military doctors want to pad their resume and do these complex procedures on wounded warriors. Because there is no malpractice, the military pushes them to do procedures they may not be qualified to do. Multiple times in my care in my transition from the military system to the civilian system this happened. One instance is when they did the first skin graft and harvested the skin off my thigh, I woke up after the surgery and it was painful. They take something that looks like a cheese grater and grate off this big patch of skin then they put this cheese cloth/wax cloth over it and stapled it around the wound to try to keep it somewhat moist and took a heat lamp to bake it. It was like torture; it was so freaking painful; it was like the worst motorcycle road rash and you are already in a lot of pain, but you tell yourself this is how it's done, suck it up.

² Jason Redman interview.

³ Ibid.

When I went to John Hopkins, they did the second major skin graft and they did the same thing to my other thigh with something that looks like a cheese grater to take a big patch of skin. The difference was they had this plastic-type stuff that looked like cellophane and they put that over the wound and it seals it so there's no pain and it doesn't hurt at all. Four months prior was the first skin graft. I asked the doc, what is this? and he said tegaderm. I asked, how long have we had this, is it new? He said no, it's been around 5 years or so. I told him what Bethesda did and he said, what? That's like twenty-year-old technology. That's a huge disconnect.⁴

In the instance of skin grafts the military sector was twenty years behind the private sector. Jay has been through 37 surgeries to reconstruct his nose, eye, jaw, and elbow. For wounded warriors going through multiple surgeries, the faster one heals, the faster one can undergo the next surgery to get the next injury fixed and get back into the fight. The healing process should be factored into care. Putting someone through twenty-year-old torture technology is not advisable and an instance of where wounded warrior care could be improved. For Jay's second issue of medical costs, perhaps Tegaderm was expensive, and that is why the military did not have it, but Tegaderm is not expensive technology. Tegaderm can be bought at CVS Pharmacy: a 10x12 centimeter 50 count box can be purchased for \$32.55. Cost cannot be the reason for the painful technology of Jay's first skin graft. It means that cutting edge technology is not available for skin grafts in the military medical system or lack of military doctor knowledge. A public-private partnership with institutions like John Hopkins University would address that issue for skin grafts, of which there will be more for other wounded warriors, and a partnership would provide access to treat them with cutting edge medical procedures and proper education.

When Jay started receiving care through the civilian sector, civilian doctors discussed wanting to do more work for wounded warriors, but said that as civilian

⁴ Jason Redman interview.

doctors they did not have the access to wounded warriors. Some accept TRICARE insurance just to be able to work with and operate on wounded warriors:

When I started meeting with these civilian doctors they told me we'd love to work more on wounded warriors, but we don't have access to them. Once again, the lack of access disconnects some of the brightest minds in the country from helping wounded warriors. The guy that put my face together is a genius in facial surgery. They transplanted a face onto a soldier and he did that surgery.⁵

With respect to the costs of wounded warrior care, sometimes the military will not tell their patients that they can get a civilian second opinion. "If you meet with a doctor specialty expert that can provide care in a manner that the military can't do, then the military has to cover that cost but they will never volunteer that because they are looking at it to try to save money. You are talking about putting guys back together for the rest of their life, but it's about money."⁶ On the average, private sector care can cost 25 percent more than military care, but if procedures were done once versus three times as in the case of Jay's nose, it would save the government money. A public-private partnership with universities could save wounded warrior lives, improve care and make care more cost-effective.

Jay believes that because he was from the special operations community, and because he was an officer, he was treated better than some wounded warriors, but he does not think the rank of a wounded warrior should matter; the sacrifice is the same. He thinks the sheer size and amount of Army and Marine Corps wounded is part of the difference in care as well:

The Army and Marine Corps are so big that it's hard to provide that hands-on care, the support network you need once you get wounded. I was in the ICU [Intensive Care Unit] in Balad and there was an Army kid right next to me. My guys flew up from Fallujah to see me. My CO [Commanding Officer] and Master Chief came to see me. Green berets, fellow SOF came to see me that didn't know us. The AC-130 crew that flew us out on

⁵ Jason Redman interview.

⁶ Ibid.

the mission when I got hurt came to see me. The doctor came up and told my boss, that kid next to me got hit by an IED and his Army unit hadn't come to see him. Part of that is the way they conduct war. They are so big that they can't chop someone to go spend time with private so and so. That's a major disconnect. I personally think that the first couple of weeks are crucial in the mental stability of how you are going to recover.⁷

In addition to LT Redman's mental stability, his attitude toward recovery is exemplified by his "Sign on the Door" that he put on his room at Bethesda. As a result of a visit by his aunt where she was very sad and crying, he wrote the "Sign on the Door" to let his friends and family know he intended on healing:

Attention to all who enter here. If you are coming into this room with sorrow or to feel sorry for my wounds, go elsewhere. The wounds I received I got in a job I love, doing it for people I love, supporting the freedom of a country I deeply love. I am incredibly tough and will make a full recovery. What is full? That is the absolute utmost physically my body has the ability to recover. Then I will push that about 20 percent further through sheer mental tenacity. This room you are about to enter is a room of fun, optimism, and intense rapid regrowth. If you are not prepared for that, go elsewhere.⁸

State of mind and mental stability are important to recovery. Jay was told by his case manager that he was moving too fast for the military medical system. The case manager was important for referrals and scheduling appointments for care. When the Bethesda case manager was overwhelmed, Redman had the Naval Special Warfare (NSW) doctor, the NSW Care Manager and the Little Creek Naval Base TRICARE Representative to help get referrals needed for civilian sector specialty care and in scheduling care. While he developed a work around with the assigned overwhelmed care manager, the problem is the inability of the DoD medical system to deal with severely wounded who require long term care arrangements. The DoD medical system was not prepared for 50,806 wounded warriors of 9/11 who require long term care.

Jay's nose was rebuilt initially by the oral maxillofacial team. If an ENT

⁷ Jason Redman interview.

⁸ Ibid.

specialist surgeon had rebuilt it, it might have saved the military medical system money and his command time lost at work for three surgeries versus one surgery by the right doctor. This example is provided to show the potential cost savings benefit a public-private partnership could provide.

Service members are allowed a second medical opinion, but that does not have to be a civilian opinion. It could be a second military opinion; however, a public-private partnership would allow a civilian doctor who is willing to do a referral appointment or work philanthropically or through a non-profit organization to treat wounded warriors. A revamped public-private partnership would allow private sector specialty care to be involved in complex cases like Jay Redman's from the beginning to save the wounded warrior pain and to reduce government long term costs. The USSOCOM Care Coalition Advocate remained the same throughout Jay's transition from military to civilian sector medical care which aided in his continuum of care.

While Jay did not return to being a SEAL operator and deploying with the same SEAL team, his reintegration with his military unit was successful. While reintegration into the military was successful for Jay, his reintegration into society was difficult at first due to the invisible wound of PTSD:

I definitely had some PTSD issues. I really had problems with crowds. I felt like people were really rude and it set me off when people were rude. When I went to Starbucks and a person was rude because they didn't get their coffee fast enough I just wanted to bash them in the skull and tell them you have no idea, you are so out of touch with the world; friends of mine have died for you to stand here and even be able to order that cup of coffee and you're acting like some jackass. Things like that set me off in the beginning. I feel like the average person has no clue what we go through and they don't. That's the reality. Now I've learned to deal with that. Now it's what we do with Wounded Wear. I want people to understand that sacrifice and what we go through, how difficult it is, and be thankful for it.⁹

⁹ Jason Redman interview.

A public-private partnership with non-profit organizations such as Wounded Wear and other non-chartered veterans organizations can raise awareness for society and make society aware of the sacrifice wounded warriors have made for other citizens to have their freedom. Wounded Wear is an example of a public-private non-profit organization partnership aiding wounded warriors by providing a clothing kit adaptable to go over bandages and prosthetics and arranging uniform and civilian clothing modifications for prosthetics. Wounded Wear will be expanded upon later in this chapter with an interview of the cofounder after other examples of public-private care of wounded warriors are examined.

Specific to Jay Redman's anecdotal example of PTSD and issues it brings for reintegration to society, a public-private partnership with non-profit organizations such as the College of William and Mary Law School's Helping Military Veterans through Higher Education (HMOVHE) clinic can help with psychological services that apply to PTSD. A public-private partnership to allow interns or medical students from partner universities, overseen by professors and licensed professionals, to assist with wounded warrior care and the Military Acute Concussion Evaluation and Diagnostic and Statistical Manual of Mental Disorders tests for TBI and PTSD would help to alleviate the care provider shortage.

The HMOVHE Clinic is an expansion of the successful collaboration between the College of William and Mary Law School's Lewis B. Puller Jr. Veterans Benefit Clinic and Virginia Commonwealth University's (VCU) Center for Psychological Services and Development. As previously mentioned in Chapter 2, the Lewis B. Puller Jr. Clinic was started by two former Judge Advocate General (JAG) officers that transitioned to law

professors and wanted to assist disabled veterans to get the services they need whether those are legal, medical, social or psychological services. The Lewis B. Puller Jr. Clinic partnership with the VCU Psychological Center Services and Development expanded to the HVMHE Clinic partnership which “provides students with real-world clinical experience under supervision by their professors while helping Virginia's veterans in education, outreach, evaluation, treatment and the benefits claims process.”¹⁰ These clinics provide wounded warriors, disabled veterans, and active duty service members with psychological services to assist in dealing with PTSD.

Other ways to make integration into society more successful are through Wounded Wear’s mission of raising the national awareness of the sacrifice of wounded warriors, their families, and the families of fallen service members. Wounded Wear cofounder and President Jay Redman expands on reintegration into society:

We are raising awareness through Wounded Wear. The government can’t afford what it takes to reintegrate service members fully into society. The government’s job is to get them as mentally and physically prepared as possible to function outside the military and then give them to society, then it falls on society and non-profits. I think that you need a driving force in the non-profits to enable these guys to find housing, quality of life and to find good jobs and it’s up to society, businesses, and people to look for those opportunities. The non-profits are the bridge for those veterans and wounded warriors and society, the companies, and educational facilities.¹¹

Public-private partnerships already help in these life-changing injuries situations, such as with vehicle adaption for those missing limbs. This public-private partnership can be built upon for vehicle adaptation. Home adaptive grants can be applied for through the VA once the wounded warrior transitions out of the military and knows where they will reside. Many other non-profit organizations exist like Home for our

¹⁰ Helping Military Veterans through Higher Education website: <http://law.wm.edu/academics/programs/jd/electives/clinics/hmvhe/index.php> (accessed 14 January 13) per interview with Professor Stacey-Rae Simcox, Esq., Adjunct Professor of Law & Managing Attorney, The Lewis B. Puller Jr. Veterans Benefits Clinic, William & Mary School of Law.

¹¹ Jason Redman interview.

Troops that also help wounded warriors by building homes that are accessible and usable given their injuries. For PTSD, there is a VA Hotline and there are DoD treatment programs, but there are wait times for those appointments. A way that a public-private partnership could help is to provide care in situations where there are prolonged wait times. For the TBI piece, UCLA has a partnership with DoD to help in discovering mental problems that result from TBI—this existing public-private partnership could be expanded. A public-private partnership would allow a non-profit organization like the Disabled American Veterans (DAV) to augment existing VA or DoD system care managers and aid in filling the care liaison role that the USSOCOM Care Coalition and Marine Recovery Care Coordinator models provide.

When a wounded warrior has a TBI and memory loss is a by-product of that TBI, the wounded warrior should not be threatened with being cancelled out of the program for missing an appointment.¹² In some Warrior Transition Units (WTUs), wounded warriors who are diagnosed with TBI receive a cell phone or an iPad to set medical appointment reminders to alleviate memory loss. The wounded warrior needs the reminder system so as not to forget appointments or waste providers' time. In this case, knowing he would have to give the phone back once he went on the Temporary Disabled and Retired List (TDRL),¹³ the wounded warrior set up the appointment reminder application on his cell phone. A public-private partnership would allow private organizations or businesses to aid in supplying iPads or phones so that once a soldier is retired or put on the TDRL, they would not have to return the iPad or phone. This memory loss issue has been

¹² Interviewee name withheld by mutual agreement. Army Wounded Warrior, interview by author, Norfolk, VA, January 3, 2013.

¹³ The Temporary Disability Retirement List (TDRL) is a list of Service Members found to be unfit for performance of military duty by reason of physical disability which may be permanent, but which has not sufficiently stabilized to permit an accurate assessment of a permanent degree of disability.

encountered by all of the wounded warriors interviewed who suffered TBI, and in other research.

In addition to providing iPads or cell phones, businesses and society can look for opportunities to bridge the gap between what the government provides in care to aiding with reintegration. One of the ways businesses could help bridge the gap is through employment of veterans. In addition to finding a job after the military, wounded warriors deal with PTSD and depression. Non-profit organizations can also aid in society's understanding of PTSD and severe depression:

Reintegration into society falls under non-profit organizations which can bridge a lot of gaps. We are still at war, but it is not on the forefront of this election like it was the last time. Some people have injuries you can visibly see but there are a lot of injuries that can't be seen. At Walter Reed last month, a soldier looked whole from the front, but his back was broken and his organs were a mess. You can't see that. Other injuries you can't see are PTSD or people with depression or anxiety. Some people don't understand it or know how to deal with it. With more people suffering from it, we've gotten a lot better. They are researching it and teaching commands how to deal with it. People are trying to do something about PTSD.¹⁴

Part of dealing with PTSD is society understanding it and part of dealing with PTSD is qualified providers to treat PTSD. Army Major Tara Dixon served two tours in Iraq as a surgeon trained in burn surgery, trauma and critical care. Part of her job was to decide whose limbs to amputate versus risking the warrior's life through blood loss. The responsibility weighed heavily upon her, and she suffered from PTSD upon return to the United States. She called Military One Source, but the first two therapists she was referred to never treated anyone with PTSD or who had been to war.¹⁵ With no successful treatment, she attempted suicide six months after returning from her second

¹⁴ Erica Redman, interview by author, Chesapeake, VA, October 2, 2012.

¹⁵ Victoria S. McLaughlin, Military Officer Association of America National Defense Industrial Association Warrior-Family Symposium, *Saluting Their Sacrifice: A Decade of Challenges and Triumphs for our Wounded Heroes and their Families*, McLaughlin Reporting LLC, November 2012, 111. http://www.moaa.org/uploadedFiles/MOAA_Main/Main_Menu/About_MOAA/Nov12_WFS.pdf (accessed November 20, 2012).

tour.¹⁶ Her family called TRICARE seeking care, but there was a two-year waitlist.

Since she could not wait that long, her family reached out for private sector care where she underwent PTSD treatment for nine months.

The long wait period for psychological treatment and therapist inexperience with war trauma showcases another reason a public-private partnership is needed. This is an example of where the College of William and Mary and VCU's Psychological Services Department consortium of Helping Military Veterans through Higher Education (HMOVHE) discussed in Chapter 3 could help with psychological services that apply to PTSD. Another example of where a university partnership stepped in to aid in mental health care is explained by Erica Redman, wounded warrior caregiver and cofounder of Wounded Wear:

It takes a great person to deal with PTSD. Jay's doesn't rule our life. Mike Day had a show on HBO about PTSD and years later, he is thrilled to be alive. His wife stresses from everything her husband went through. Mike lost guys on the mission he was wounded on, but Jay didn't. Losing someone on a mission or not can affect how a person deals with PTSD. There's a UCLA [University of California Los Angeles] partnership that is doing a lot to aid in PTSD treatment.¹⁷

Operation Mend, the UCLA partnership with DoD that Erica described assisted another Navy SEAL wounded warrior Mike Day, shot over 20 times. Since 2007 the program has expanded to optimize the healing of body, mind and spirit. In addition to plastic and reconstructive surgery, Operation Mend provides mental health support for wounded warriors and families.¹⁸ In addition to the UCLA Operation Mend partnership

¹⁶ Victoria S. McLaughlin, Military Officer Association of America National Defense Industrial Association Warrior-Family Symposium, *Saluting Their Sacrifice: A Decade of Challenges and Triumphs for our Wounded Heroes and their Families*, McLaughlin Reporting LLC, November 2012, 112. http://www.moaa.org/uploadedFiles/MOAA_Main/Main_Menu/About_MOAA/Nov12_WFS.pdf (accessed November 2012).

¹⁷ Erica Redman interview.

¹⁸ University of California Los Angeles, "See What UCLA is Doing for Veterans," UCLA Veterans, 1. <http://www.veterans.ucla.edu/seeucla/default.htm>. (accessed 14 March 2013).

with the DoD which specializes in mental health support for wounded warriors and orthopedic reconstruction of limbs, there are ten other examples of public-private partnerships between the DoD and UCLA.

More public-private partnerships with universities across the nation that specialize in TBI treatment, brain damage, mental health problems to include depression and PTSD, burn treatment, and orthopedic reconstruction, would improve wounded warrior care. In January 2013, after research and interviews for this thesis were initiated, the author discovered a new program that was established by the White House called Joining Forces which is the largest example of a public-private partnership for wounded warrior and wounded veteran health care between DoD and universities. Approximately 130 schools associated with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) have pledged their support of the Joining Forces initiative:

As part of First Lady Michelle Obama and Dr. Jill Biden's Joining Forces initiative, the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) committed to creating a new generation of doctors, medical schools, and research facilities that will make sure our heroes and their families receive the care worthy of their sacrifice. Recognizing veterans, service members and their families' dedication and commitment, 130 schools associated with the AAMC and AACOM pledged to leverage their missions in education, research, and clinical care to train the nation's physicians to meet the unique health care needs of the military and veterans communities.¹⁹

One way the Joining Forces initiative could be used is for ways to treat infection. While not every wounded warrior can go to a Navy diving facility for treatment of MRSA infection in a hyperbaric chamber, there are universities that have hyperbaric chambers, and the DoD and VA could explore a public-private partnership with those

¹⁹ The White House Office of the First Lady, "First Lady Michelle Obama Announces Major Coordinated Effort by America's Academic Institutions to Combat PTSD & TBI," Office of the First Lady, <http://www.whitehouse.gov/the-press-office/2012/01/11/first-lady-michelle-obama-announces-major-coordinated-effort-americas-ac> (accessed March 14, 2013).

universities to treat infection. A PTSD/TBI study to treat wounded warriors with hyperbaric treatment is being conducted at Louisiana State University and “results will be measured by brain blood flow imaging, written tests for memory and thinking, and questionnaires about quality of life and health.”²⁰ Once the test study is complete, a public-private partnership for use can be explored under Joining Forces.

Another challenge Erica mentioned for Jay Redman, Navy SEAL, was that he would have to undergo an elbow replacement at some point in his life and a public-private partnership such as Operation Mend between University of California Los Angeles (UCLA) and DoD or Joining Forces could be expanded to conduct such an elbow replacement. Operation Mend was a White House effort established in 2007 as a means to connect the best military resources with UCLA health system skills to heal U.S. service members disfigured or injured in Afghanistan or Iraq. In 2007, the goal of Operation Mend was specific to military members with severe facial injuries and burns being treated by the best burn center in the Army and the nation's best reconstructive and plastic surgeons. Operation Mend has been referred to by Joining Forces as an example to follow and as part of the AAMC’s involvement in Joining Forces, UCLA and other universities in Joining Forces are “examining the medical school curriculum as a whole and beginning to identify opportunities to engage our students in efforts to define and address the needs of military service members and their families.”²¹

²⁰ Harch Hyperbaric Oxygen Treatment, “Louisiana State University Health Sciences Center To Conduct [sic] a Study of Hyperbaric Oxygen Therapy Treatment for Wounded Warriors with TBI & PTSD,” <http://www.hbot.com/article/tbi-ptsd-treatment-hyperbaric-oxygen-therapy-wounded-warriors-traumatic-brain-injury-andor> (accessed March 11, 2013).

²¹ Gina Shaw, “Joining Forces Initiative with the White House: Academic Medicine Commits to the Troops,” Association of American Medical Colleges, February 2012. <https://www.aamc.org/newsroom/reporter/feb2012/273802/joiningforces.html> (accessed March 14, 2013).

With 130 universities in the Joining Forces public-private partnership, it is possible for some of those universities to have prosthetic adjusters on staff which would improve wounded warrior care by increased availability of prosthetics adjusters at more locations and more prosthetics replacements being available when needed. Better care could make a difference in separation or retention in the military as the Marine whose story was told in Chapter 2 chose to separate due to infection complications and losing more of his limb. More care providers would lessen the burden on existing care providers many of whom work unpaid overtime to try to meet the need for wounded warrior care.

The commitment by the universities to the Joining Forces initiative is a huge step toward improving wounded warrior care. These universities would benefit from following the model created by the College of William and Mary and VCU for the Helping Military Veterans through Higher Education (HMOVHE) clinic. Wounded warriors suffering from PTSD or TBI would benefit from psychological department services as would their families.

Being injured does not just affect the wounded warrior, it affects the entire family. The Redman's youngest daughter (two years old at time of injury) had separation anxiety when her mother Erica was gone to take Jay in for surgery. Bethesda Naval Hospital was not able to keep Jay the seven months he needed to recover, and because the Navy did not have Warrior Transition Units in 2007, Jay was assigned to his parent command and Erica had to take care of him:

I had to learn tracheotomy care. I washed the blood out of Jay's hair. At five weeks, he came home from Bethesda with pins in his arm so I had to learn pin care too. I took care of the stomach tube because he couldn't feed himself. The tracheotomy part was horrible, the worst. They capped it but his jaw was messed up. He could not open his

mouth enough for surgery so he had a tracheotomy for seven months. A plastic surgeon closed it up when they took it out.²²

What Erica described about what she had to learn to take care of Jay shows the burden placed on caregivers of wounded warriors. Part of the caregiver burden is helping to arrange medical appointments. During Jay's recovery, they asked to talk to a specialist about rebuilding Jay's nose:

Jay called him and the doctor had heard nothing from the military system. Jay asked if there would be a good reason for you to see him now (several months into injury) and the doctor said do not worry about a referral as I will do a free consultation. He saw Jay, said he couldn't do the surgery, but he knew a micro-vascular surgeon who could. The doctor in Chicago referred Jay to another doctor.²³

The above example illustrates that many doctors are willing to provide a free consultations in special cases for wounded warriors. Building a registry of these doctors would aid wounded warriors by knowing where to start to find doctors that can provide assistance in cases where military medicine does not have the expertise.

In addition to Jay's gunshot wound to the face requiring specialty care, his gunshot wounds to the elbow required a specialty doctor in the civilian sector, which provides another model for the public-private partnership:

Bethesda wanted to stabilize his arm but he had bone growing out of his arm. The bone was blown out by high velocity rounds. He had bone particles, but the wound closed up. They gave Jay H.O. [Heterotopic Ossification] and they said to heal it, they had to lock it. Bethesda said it was as good as it would get; nobody would touch his elbow and arm, but they found a civilian doctor in shock trauma that said he thought he could get Jay some movement. He took missing chunks of the elbow bone particles and cut up the H.O. grown bone and made Jay a new elbow, but the H.O. in his elbow kept growing. He had to undergo radiation to cease elbow growth. Since then, Jay and I have been able to refer two other wounded warriors with similar injuries to this shock trauma doctor.²⁴

The wounded warrior peer-mentoring and caregiver-mentoring provided by Jay and Erica helped two other wounded warriors through shock trauma cases for which the

²² Erica Redman interview.

²³ Ibid.

²⁴ Ibid.

military medical sector did not have specialists. This is another area where the Joining Forces initiative military medical system partnership with 130 college medical universities could be expanded. This is a case where a public-private partnership with a university medical department would be beneficial as interns or students could research and explain complex procedures to wounded warriors.

The upside of private sector care is trauma specialists, but the downside to leaving the military medical system involves obtaining pain medicine prescriptions:

When we made the decision to go to the doctor at John Hopkins University and deal with the civilian side of medicine, we lost a lot of support that we had in the military system. He [Jay] got discharged from shock trauma in Baltimore, MD, and they would not fill his pain medicine prescriptions. I was told to take him to the VA [Department of Veteran Affairs] hospital right out of surgery to get liquid morphine and the VA laughed at me. The command tried to help, but could not rush getting a referral or prescription in the medical system to Baltimore, so I had to drive Jay to Portsmouth for pain medicine.²⁵

Providing pain medicine prescriptions following surgery will need to be coordinated in a public-private partnership. Besides plastic surgeons that do philanthropic work on wounded warriors, as shown in the second case study, there are also philanthropic organizations that help wounded warriors benevolently and in finding jobs.

I've utilized myriad public/private services, from the Bob Woodruff Foundation²⁶ (my wife and I, and 6-7 other Wounded Warriors were on Good Morning America with Bob Woodruff back in 2010), to a very small, private organization that gives a heartbreakingly good bit of themselves (and they don't have much to spare) to help wounded warriors. I suspect that what you and the public tends to see/hear is very different from what reality is for many--too many--wounded warriors. I read this past weekend that 10.9% of veterans are unemployed; I also read (via one of the wounded warrior updates a few months back) that a staggering 40+% of seriously wounded are unemployed. You don't

²⁵ Erica Redman interview.

²⁶ The Bob Woodruff Foundation is a nonprofit dedicated to ensuring injured service members, veterans and their families are thriving long after they return home helping to heal physical and psychological wounds of war; aids in navigating the maze of over 40,000 nonprofits providing services to veterans. Bob Woodruff Foundation, "About Us," ReMIND. http://remind.org/about_us (accessed March 31, 2013), 1.

tend to meet these folks at the “feel good” one-off wounded warrior events. Some of these folks are struggling to make ends meet every day.²⁷

For wounded warriors that are struggling to make ends meet, there are non-profit organizations that can help, the VA has a hotline, and other wounded warriors step up to help. Jay Redman and Tyler Southern help other wounded warriors through Wounded Wear, and the Air Force (AF) wounded warrior helps out through the AF Wounded Warrior Office contacts he is given for peer-mentoring:

I do my best to help/mentor those others as I can (the AF Wounded Warrior Office periodically sends some wounded warriors my way so I can peer mentor them), and that's ALWAYS a very quiet, no-fanfare, peer-mentoring to help someone in real immediate need of getting through a particularly rough patch. The phone calls at 1030 at night from a wounded warrior struggling with nightmares or worse--those scare the shit out of you, and sap a tremendous amount of energy. You don't and won't see that in the news.²⁸

The VA does what it can, but it is often overwhelmed and therefore not as effective as it needs to be due to the volume of individuals needing specialized care that may not be available at the given location. This also applies to some of the smaller WTUs that are not co-located with military bases. Consequently, it becomes an issue for the local communities where wounded warriors transition. Society is taking responsibility as illustrated by multiple examples of philanthropic individuals and university programs described above by wounded warriors. In addition to the Lewis B. Puller Jr. Veterans Benefit Clinic at the College of William and Mary Law School discussed earlier in this chapter, South Florida University is working with wounded warriors and a Wake Forest University, North Carolina, program is working with Camp Lejeune Wounded Warrior Battalion on the cutting edge of growing organs and skin with just a sample of the service member's deoxyribonucleic acid (DNA).

²⁷ Interviewee name withheld by mutual agreement. Air Force Wounded Warrior, email to author, September 18, 2012.

²⁸ Ibid.

Non-profit Organization at a University Partnership

Adjunct Professor Stacey-Rae Simcox, Esq., is the managing attorney of the Lewis B. Puller Jr. Veterans Benefits Clinic at the College of William and Mary Law School discussed in the previous chapter. The law school students, overseen by professors, assist veterans and active duty military members entering the Physical Evaluation Board (PEB) process with filing disability claims to obtain benefits. The Lewis B. Puller Jr. Clinic also assists veterans and service members with TBI and PTSD diagnoses in obtaining upgrades if their injuries were recorded as personality disorders and, if warranted, aid in retroactive medical payment.

The most challenging thing that Professor Simcox has helped with while serving at the Lewis B. Puller Jr. Clinic since 9/11 is TBI which is not exclusive to combat.²⁹ In one case, the clinic helped a homeless shelter veteran who had a TBI untreated from the 1980s and it developed into dementia. Dementia is a danger of not treating TBI.³⁰ The clinic researched the issue further to discover that the veteran's SF95³¹ said he suffered a beating to the head at S.E.R.E. [Survival, Escape, Resistance, and Evasion] school. This is a case that proves TBI is broader than combat, that it does not manifest the same way in every person, and sometimes it intertwines with PTSD.³² It is hard to parse out what symptoms are TBI and which symptoms are PTSD-related.³³

Professor Simcox's helps wounded warriors and injured veterans because when she and her husband finished their active duty commitments, they had a difficult time navigating the VA process. She thought, "if two JAGs who were supposed to be experts

²⁹ Adjunct Professor of Law and Managing Attorney Stacey-Rae Simcox, Esq., The Lewis B. Puller Jr. Veterans Benefit Clinic, William & Mary School of Law, phone interview by author, January 14, 2013.

³⁰ Ibid.

³¹ SF95 is a form to file a Claim for Damage, Injury or Death.

³² Adjunct Professor of Law and Managing Attorney Stacey-Rae Simcox, Esq. interview.

³³ Ibid.

were overwhelmed, then the average Joe on the street probably won't understand it as well as those who are wounded or those struggling with cancer.”³⁴

To help veterans understand the VA-coded regulations and to aid veterans, the Lewis B. Puller Jr. Clinic deals with disconnects in the disability rating process. Merging of the VA and PEB process has helped.³⁵ The rating process is done only once vice twice through the Integrated Disability Evaluation System (IDES) board process explained in Chapter 3 (see IDES chart on page 33). Professor Simcox explains her experience with the disability rating process:

My experience is that the VA is so overwhelmed that they don't always get the answer right the first time. For a wounded veteran, if they don't get it right they could end up being separated at 20 percent when they should have received a 50 percent rating. It's hard in the new system to go back to the Army or Navy Board of Corrections for Military Records to get it changed to a medical retirement because the system is so overwhelmed. It is a manpower problem; the VA can't send all the records back a second time.³⁶

By reviewing medical records and narrative summaries and highlighting issues for the disability raters, the Lewis B. Puller Jr. Veterans Benefit Clinic saves time and aids in reintegration by helping wounded warriors and veterans receive benefits more quickly. If other law schools across the country adopted this model, the backlog of VA claims could be cleared more quickly. One big difference Professor Simcox has seen between active duty, National Guard (NG) and Reserve units is that complete medical records are lost for NG and Reservists returning from Afghanistan. Proving what the service member says happened and what actually happened is difficult without a medical record.³⁷

Professor Simcox observed that access to medical care in the DoD system is better than in the VA system because people can get appointments. She provided an

³⁴ Adjunct Professor of Law and Managing Attorney Stacey-Rae Simcox, Esq interview.

³⁵ Ibid.

³⁶ Ibid.

³⁷ Ibid.

example of VA wait times for treatment, “For veterans with 100 percent PTSD, some have a waiting time of three months for help. The problem is there are not enough VA care providers.”³⁸

If back logged, care prescribed at VA medical centers for PTSD could be referred to the private sector in a public-private partnership or through university partnerships for university professionals to treat wounded warriors with PTSD. Professor Simcox believes non-profit organizations are key to veteran reintegration and employment, but that universities can help in other areas as well:

With grants we try to help. We pay for homeless veterans to get evaluations by fund raising. Students volunteer to help provide veterans services such as medical and through the psychology department, and nursing students at ODU [Old Dominion University]. Other programs reintegrate veterans to help them not be monopolized when they get large sums of money awarded. For sixty thousand dollars in back pay claims to a single mom and for forty-five thousand dollars in back claims pay to a homeless man with no furniture, the school offers financial counseling through the Helping Military Veterans through Higher Education [HMOVHE] Clinic to help them not be taken advantage of. The Business School aids in finding employment. It is limitless what universities can do.³⁹

The HMOVHE clinic mission: “In recognition that veterans disability issues go beyond their legal claims for benefits, William & Mary Law School has partnered with Virginia Commonwealth University's Center for Psychological Services and Development to help veterans address all of the health and disability concerns that may arise from their service to our nation.”⁴⁰

The law school pays the salary of professors helping to train students to review PEB cases assisted by a grant from the Jessie Ball DuPont Fund given to the HMOVHE Clinic for that mission. The universities in the HMOVHE Clinic aid in financial

³⁸ Adjunct Professor of Law and Managing Attorney Stacey-Rae Simcox, Esq., interview.

³⁹ Ibid.

⁴⁰ College of William & Mary Law School, “William & Mary Law School Helping Military Veterans through Higher Education (HMOVHE) Clinic,” http://www.has.vcu.edu/psy/cpsd/welcome_mat/welcome.html (accessed January 14, 2013).

counseling, nursing services, psychological care, and business schools offer advice to help veterans find employment. In addition to the College of William and Mary and VCU, the other universities that form the HVMHE Clinic are George Mason University, Eastern Virginia Medical School, Hampton University, James Madison University, Lynchburg College, Northern Virginia Community College, Old Dominion University, Radford University, Shenandoah University, Tidewater Community College, the University of Virginia, and Virginia Tech. The HVMHE Clinic is a model that can be expanded to universities outside of Virginia to help veterans in all states.

From Professor Simcox's experience, TBI and PTSD are the two biggest issues for society that the Lewis B. Puller Jr. Clinic deals with. Professor Simcox believes Wounded Wear is bringing society closer to those who have served and for reintegration to society:

Combat wounded and Purple Heart shirts draw attention to service. It reminds people every day everywhere. They took images off TV; the news used to report casualties, but you don't hear it on the news anymore. Everyday Wounded Wear is bringing attention to wounded warriors and soldiers' service, but some people would rather forget.⁴¹

Marrying up the DoD and VA disability rating processes has brought significant problems for service members with PTSD who were discharged for misconduct and in some cases had PTSD inappropriately listed as an adjustment disorder or a personality disorder:

Before PTSD was front and center, service members would be called "pogues" or told this guy stinks for causing problems, send them to psych and they'd get diagnosed with a personality disorder which is an easy administrative chapter. I can't tell you how many of those I've processed and it was really PTSD. Sometimes PTSD is still getting processed that way. When discharged, someone with PTSD should be labeled with PTSD, not an adjustment disorder. A veteran labeled with personality disorder cannot get help or benefits with a misconduct discharge. This is not stated to slam the VA, but how does

⁴¹ Adjunct Professor of Law and Managing Attorney Stacey-Rae Simcox, Esq., interview.

the VA have time to go in detail on records with back log? They do not have enough people to meet the task. Students help go through all the records.⁴²

To show the extent of service members with PTSD who were discharged for misconduct and, in some cases, had PTSD inappropriately listed as an adjustment disorder or a personality disorder discussed by Professor Simcox, the Iraq and Afghanistan Veterans of America (IAVA) cites 31,000 possible cases where this was misdiagnosed. IAVA is a non-profit, non-partisan organization and “is concerned that misdiagnoses of mental disorders is cheating veterans out of benefits.”⁴³ Representative (Rep.) Tim Walz of Minnesota introduced a bill to Congress (along with cosponsors Rep. Walter B. Jones, North Carolina; Rep. Thomas Rooney, Florida; Rep. Niki Tsongas, Massachusetts), House Resolution 975 Servicemembers Mental Health Review Act of 2013, to Congress which has been endorsed by IAVA, to review more than 31,000 discharges for personality or adjustment disorders for anyone separated from 9/11/2001 through December 31, 2014 when fitness for duty was the cause.⁴⁴

University Partnerships

There are over 2,100 veterans and their families enrolled as students at the University of South Florida (USF) in Tampa, Florida, which is another example of a university partnered with the DoD for wounded warrior care and research.⁴⁵ USF conducts research related to veterans' reintegration, rehabilitation, and resilience. USF's current research programs for solutions can serve as a proof of concept for other

⁴² Adjunct Professor of Law and Managing Attorney Stacey-Rae Simcox, Esq., interview.

⁴³ Rick Maze, “Bill Would Review Discharges for Possible PTSD,” *Marine Corps Times*, March 6, 2013, <http://www.marinecorpstimes.com/news/2013/03/military-personality-disorder-discharges-review-walz-bill-030613w/> (accessed March 7, 2013).

⁴⁴ Ibid.

⁴⁵ University of South Florida, “USF Research and Innovation,” Veterans Reintegration and Resilience, <http://www.research.usf.edu/vri/> (accessed December 31, 2012).

universities to follow. Roughly 25 percent of Florida's 1.72 million veterans reside in counties served by USF. USF is affiliated with two major VA hospitals: the James A. Haley VA Hospital, adjacent to USF's main campus, and Bay Pines VA Hospital across Tampa Bay.

This research partnership with USF can provide an example for other universities for wounded warrior care and veteran research in the Joining Force Initiative. In addition to USF where the DoD and VA have a public-private university partnership with the USF, there are four other polytrauma rehabilitation centers in the VA medical system: San Antonio Army Medical Center, formerly known as Brooke Army Medical Center, which includes a public-private partnership with the Center for the Intrepid Burn Center;⁴⁶ Palo Alto VA Hospital which works with the Wounded Warrior Battalion at Camp Pendleton, California; Minneapolis VA Medical Center, and Hunter Holmes McGuire VA Medical Center in Richmond, Virginia. The polytrauma rehabilitation centers handle all aspects of acute, inpatient rehabilitation for severe injuries (including TBI) of more than one organ system. There also 23 polytrauma network outpatient sites which coordinate care with the inpatient polytrauma rehabilitation centers. The severity of the injury and the physical medicine and rehabilitation services required after discharge from a Medical Treatment Facility (MTF) determine whether a service member is transferred from a DoD MTF to a VA polytrauma rehabilitation center for inpatient care.

⁴⁶ The Center for the Intrepid (CFI) is an advanced outpatient rehabilitation center which blends therapy, simulation, and extreme sports. Intrepid Fallen Heroes Fund, "The Center for the Intrepid," <http://www.fallenheroesfund.org/About-IFHF/Fund-History/The-Center-for-the-Intrepid.aspx> (accessed December 31, 2012).

Two of the five polytrauma centers have a public-private partnership with a university or a philanthropic organization. A public-private partnership with universities at the other three locations could better support wounded veterans. A public-private partnership at these locations would maximize the resources available to care for wounded warriors.

Now that university partnership examples have been explained, examples of non-profit partnerships will be given and show how a public-private partnership could benefit wounded warrior care and reintegration.

Non-profit Partnerships

A way to help deal with the issues that post-war casualties cause for society is through a public-private partnership with non-profit organizations. Two non-profit organizations stepped in to help the Army wounded warrior discussed in Chapters 1 and 2 through his recovery: Wounded Wear and Keeping Warriors Outdoors. These two non-profit organizations missions will be explained in further detail now.

Erica Redman, Navy SEAL LT Jason 'Jay' Redman's wife, is the cofounder and Vice President of Wounded Wear. Wounded Wear is a non-profit organization that works with combat wounded who have been injured since 9/11 as well as those injured before 9/11 and has assisted veterans of World War II, the Korean War, Vietnam, and the Beirut Embassy bombing. In support of its mission to raise the national awareness of the sacrifice of wounded warriors, their families, and the families of fallen service members, Wounded Wear advocates on behalf of and facilitates opportunities for those who have sacrificed, as well as providing free clothing kits and clothing modifications to wounded warriors to empower them to rediscover the hero within.

Erica Redman talks about why she and Jay founded Wounded Wear:

We started Wounded Wear to help others with what from what we found out from our own personal experiences. Five years later we are still learning about organizations and opportunities for wounded warriors. I want to pass on the information because when it first happened to us, it was like drinking from a fire hose. You can get so overwhelmed that you just want to shut it all off. We want to share what we've gone through and maybe that will make it easier for people going through it now.⁴⁷

Through Wounded Wear's experience of delivering clothing kits to combat wounded at Bethesda, Walter Reed, Camp Lejeune, Portsmouth Patriot Inn, and other wounded warrior treatment centers, Erica has met wounded warriors "that do not have wives or mothers or a support system and I worry about them not having a caregiver. In one of the wounded warrior cases we assisted, he did not get paid TSGLI [Traumatic Servicemember's Group Life Insurance] so we pointed him in the right direction."⁴⁸

As an organization, Wounded Wear hopes to do more advocacy work for wounded warriors. The public/government system can handle wounded warrior care and reintegration up to a point, and then they can transition to a designated non-profit organization. Transition assistance can be done through a scholarship or a program to teach them skills that help them get a job.

One such non-profit organization that offers wounded warriors a scholarship is called the Wyakin Warrior Foundation which believes in empowering wounded warriors through mentoring and service and whose motto is "Scholarship, Mentoring, Training and Networking for Severely Wounded or Injured Veterans."⁴⁹ The Wyakin Warrior Foundation is a 501c(3) nonprofit organization whose mission is "providing a full-spectrum education and professional development program for severely wounded,

⁴⁷ Erica Redman interview.

⁴⁸ Ibid.

⁴⁹ Greg Thomas email to author August 22, 2012 and <http://www.wyakin.org>.

injured, or ill Post 9/11 veterans, designed for collegiate success and resulting in a rewarding career after graduation.”⁵⁰ It provides a one-on-one, custom, mentoring program by the nation’s top leaders in business, industry and government service. While in school, Wyakin Warriors must complete a service project that benefits other wounded warriors.⁵¹ After graduation, they stay connected for life as they progress in their careers.

Each wounded warrior has their own challenges; finding a job is just one of them. Each has their own set of concerns with where they are in their life. Society can be made more aware of our nations’ wounded and their recovery through Wounded Wear’s mission of raising awareness of the sacrifice made by wounded warriors and their families. Non-profit organizations can fill the gap of clothing modifications to go over prosthetics and by wearing combat wounded t-shirts and Purple Heart polo shirts that let society know the person is a wounded warrior and was not hit in a car accident.⁵²

Wounded Wear receives part of its funding through another non-profit organization called the Boot Campaign, which was developed by five women in Texas who read Marcus Luttrell’s book *Lone Survivor: The Eyewitness Account of Operation Redwing and the Lost Heroes of SEAL Team 10* and wanted to do something to give back to wounded warriors. The Boot Campaign’s mission is to bridge the gap between American society and the warriors that protect it. The premise of their campaign is for American society to wear combat boots with everyday clothes, which can lead to a conversation about why the individual is wearing combat boots. More often than not,

⁵⁰ Greg Thomas email to author August 22, 2012 and <http://www.wyakin.org>.

⁵¹ According to Native American legend, a *wyakin* is a spiritual guide that advises and protects a person throughout life. As a rite of passage, a young Native American was taken to an isolated mountain location where the child remained alone until the wyakin (often an animal such as an eagle or a wolf) appeared in a vision or dream. Greg Thomas email and <http://www.wyakin.org> quote (Paraphrased from “Our Brothers’ Keeper” by Richard Littell), August 22, 2012.

⁵² Erica Redman, interview by author, Chesapeake, VA, October 2, 2012, interview 3.

when someone hears the reason, they also decide to join in and “get their boots on.” The goal of the Boot Campaign is to see 1.4 million Americans wearing combat boots, which is their way of thanking the 1.4 million active duty military members serving in 150 countries overseas and in the United States. The funds from the boots purchased support non-profit organizations in assisting wounded warriors. “Boot purchases and donations help provide PTSD counseling services to warriors and families, adaptive clothing for wounded military, therapy services, prosthetics, mobility equipment, counseling, wellness retreats for military families, mortgage free home donations, academic and employment assistance.”⁵³ Each of the seven non-profit organizations (Lone Survivor Foundation, Military Recovery Fund, Military Warriors Support Foundation, Wounded Wear, Not Alone, Special Ops Survivors, and Armed Forces Foundation) that receive Boot Campaign donations support different aspects of wounded warrior reintegration.

A public-private partnership with non-profit organizations such as the Boot Campaign, Not Alone, and Wounded Wear raise awareness for wounded warrior reintegration in society and help alleviate the consequential costs to society of PTSD by aiding wounded warriors suffering from PTSD and empowering them to get help if needed through counseling services. Not Alone is a national organization that provides free counseling services to warriors and families affected by combat stress and PTSD. The Boot Campaign partnership for raising awareness could be expanded to more than just Texas, California, Virginia, Washington DC, and Tennessee.

⁵³ The Boot Campaign, “You Can Help,” The Boot Campaign, <http://www.bootcampaign.com/donate/> (accessed December 31, 2012).

The Army wounded warrior in the third case study who suffers from PTSD describes a similar struggle that AF and Navy wounded warriors experienced in finding what activities they are good at post-injury:

There are challenges that come with life changing injuries. There are changes that are positive and negative. There are things you used to be able to do before like being infantry, boxing, jujitsu, and wrestling that I'll never be able to do again. You struggle to find something else you are good at. I am good at bow hunting and fishing, and through Kip West Outdoors now called Keeping Warriors Outdoors, I have gotten to go on some hunting trips and help other wounded warriors.⁵⁴

Through hunting with the non-profit organization Keeping Warriors Outdoors (KWO), the Army wounded warrior has overcome a challenge and been able to help other wounded warriors through that organization, giving him a purpose. A fellow wounded warrior friend of his who was killed in the November 2012 Texas parade float hit by a train left behind a son who struggled and gave his mother a hard time after his father's death. Through KWO, the Army wounded warrior took a fellow wounded warrior and his buddy's son hunting, which helped the son overcome his grief.⁵⁵ Wanting to help other wounded warriors and their families is a common theme among wounded warriors. The KWO mission is to get injured troops away from the hospitals and back into a more comfortable environment--the outdoors--through hunting and fishing. "Every day the number of wounded troops coming home increases and so do the needs of KWO. Once these brave men and women are back stateside, their recovery and our work begins."⁵⁶

Another non-profit organization that conducts outdoor activities to reintegrate wounded warriors into society is the Gathering of Mountain Eagles whose mission is to

⁵⁴ Army Wounded Warrior interview.

⁵⁵ Ibid.

⁵⁶ Keeping Warriors Outdoors, "Honoring our Fallen, Supporting our Wounded," Keeping Warriors Outdoors, <http://www.kipwestoutdoors.org/> (accessed January 3, 2013).

provide opportunities for wounded or injured American military service members and select family members to enjoy the therapeutic effects of adventure activities and relaxation opportunities primarily within the states of West Virginia and Virginia. It also provides occasions to thank the warriors, enhance public awareness and increase aid for all programs supporting those wounded Americans and their families.⁵⁷ The Gathering of Mountain Eagles is a relatively new non-profit organization founded by retired soldiers and their families who want to help wounded warriors of all Services from the wars in Iraq and Afghanistan.⁵⁸

In addition to the non-profit organizations mentioned, Virginia funds an organization that assists wounded warriors at the state level called the Virginia Wounded Warrior Program (VWWP) which bridges the gap between DoD and non-profit organizations. The VWWP has helped a veteran who was going to lose his home for not paying rent, but they also dug deeper to discover the problem was losing his job, and that he lost his job due to untreated PTSD. The VWWP enrolled the veteran in a Transition Assistance Program (TAP) where he was taught to write a resume and successfully did so. The VWWP put him in contact with another veteran non-profit called Dress for Success to get clothes for an interview and where he was able to get a job. He and his family went to counseling through the VA for PTSD. The family's home life is much improved, the veteran is holding down a job now and able to pay his rent. VWWP discovered the root cause of the problem which was PTSD and provided the tools to the veteran and his family for himself and his family to receive the care they needed by putting the family in contact with other non-profit organizations.

⁵⁷Gathering of Mountain Eagles, "C," Gathering of Mountain Eagles, <http://www.mountaineagles.org/> (accessed March 3, 2013).

⁵⁸ Michael Bennett, interview by author, Norfolk, VA, August 23, 2012.

The Governor started VWWP in 2008 due to the veteran population size in Virginia and to fill the gap in services that the DOD and VA could not provide. San Antonio, Texas has the largest population of veterans and Hampton Roads, Virginia is the second largest with 258,000 veterans in the area. Virginia is only one of three states with veteran programs. VWWP helps veterans of all eras. If states with large veteran populations want to help society not suffer the consequential costs of PTSD, a program like VWWP should be implemented.

Each of the non-profit organizations and the VWWP discussed in this chapter helped wounded warriors interviewed for this thesis and each has a different niche on wounded warrior reintegration to society by raising awareness, through scholarship or through outdoor activities. One organization cannot aid all wounded warriors or provide all services needed. It takes a partnership as shown with the VWWP example. The American Legion and Disabled American Veterans are chartered veterans service organizations that help wounded veterans with things outside of the scope of the VA. Wounded Wear, the Boot Campaign, the Wyakin Warrior Foundation, Keeping Warriors Outdoors, and the Gathering of Mountain Eagles are examples of non-profit organizations and non-chartered veterans service organizations that could be built into a broader public-private partnership to improve wounded warrior reintegration and be the bridge between what DoD and the VA can provide. In addition to the non-profit and university partnerships already discussed, philanthropic organizations are another example of public-private partnerships to improve wounded warrior care and reintegration.

Philanthropic Partnerships

A philanthropic organization example is the Pentagon partnership with the Intrepid Fallen Heroes Fund, a private foundation, which is raising \$100 million to build medical centers on military bases specializing in treating TBI and PTSD. Since September 11, 2001, the Intrepid Fallen Heroes Fund has built a TBI Center of Excellence in Bethesda, MD, and an amputee and burn rehabilitation center in the VA polytrauma center in San Antonio, TX called the Center for the Intrepid discussed in the university partnership section of this chapter. Clinic groundbreakings have occurred at Fort Belvoir and Camp Lejeune. Additional clinics are planned at Fort Carson, Fort Campbell, Fort Bragg, Fort Bliss, Fort Hood, and Joint Base Lewis-McChord. The idea behind these clinics on the nation's largest military installations is to use "a hub-and-spoke model to channel the latest patient data up to research hubs and push down treatment models to the doctors and therapists."⁵⁹

"We have felt that buildings are often catalysts for better care and attention," said Marty Edelman, a trustee of the fund and a New York-based real estate lawyer. "We don't pretend to be doctors so we build the best facilities that money can buy and we engage the entire American community to support us."⁶⁰

Colonel Nikki Butler, Director of the Rehabilitation and Reintegration Division for the Office of the Army Surgeon General, said the Army has already been treating soldiers with TBI and PTSD at these installations, but the Centers for the Intrepid enhance care:

⁵⁹ Kristin M. Hall, "Building The Best For Injured Soldiers: Nonprofit's medical clinics focus on brain injuries, PTSD," *Washington Post*, August 22, 2012, 1.

⁶⁰ Ibid.

You want to be able to treat them holistically, in that patient care setting, rather than sending them all over the place. It may require different types of providers, but I think what you get is efficiency and eventually less demand on the system and better use of the patient's time and provider's time.⁶¹

⁶¹ Ibid.

CHAPTER 5: RECOMMENDATIONS

A public-private partnership of DoD and VA health care providers with non-profit organizations, universities and philanthropic organizations would improve wounded warrior care and reintegration into society reducing the consequential costs of PTSD and TBI on society, and as a viable solution to examples of wounded warrior care disconnects presented in this thesis. As previously discussed, the College of William and Mary School of Law's Lewis B. Puller Jr. Veterans Benefits Clinic aids in the disability rating process and has helped wounded warriors by tabbing medical records and the narrative summary to go before the PEB. The records being tabbed allow the VA disability raters to go through the records faster because they know where to look to find the injuries to be rated for disability. The disability rating system is not standard across the board, but the success of the Lewis B. Puller Jr. Veterans Benefit Clinic's ability to tab the narrative summary and medical record before the PEB has resulted in fewer appeals to the VA after the fact and the disability ratings being more accurate. This model should be followed in law schools across the country to decrease VA disability rating appeals countrywide. A grant to the William and Mary School of Law Lewis B. Puller Jr. Veterans Benefit Clinic to capture this model and then export the model to law schools across the country is needed and is a cost effective means for DoD to support public-private initiatives.

The partnership that started between the William and Mary Law School with Virginia Commonwealth University to provide psychological services to veterans that are seeking assistance with disability claims has expanded into the Helping Military Veterans

through Higher Education (HMEVHE) Clinic in universities across Virginia providing financial counseling services, nursing services, advice from business school students to veterans seeking employment. Expanding Virginia's HMEVHE Clinic model to other state universities would improve wounded warrior care and reintegration countrywide.

After the start of research and interviews for this thesis in August of 2012, a new program was established by the White House called the Joining Forces initiative, which is the largest example of a public private partnership discovered during research. The 130 schools associated with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine who have pledged support to Joining Forces should follow the model Virginia universities developed for the HMEVHE Clinic for wounded warrior and wounded veteran health care. Expanding the public-private partnerships with universities across the nation that specialize in TBI treatment, brain damage, mental health problems to include depression and PTSD, burn treatment, and orthopedic reconstruction would improve wounded warrior care. Another model that could be expanded for the 130 schools in the Joining Force initiative is the Operation Mend model at UCLA.

The DoD and the VA lack true interoperability for the seamless exchange of electronic health records for wounded warrior care and the broader force. Individual medical records in the DoD system are given in hard copy (paper) to the VA, but providing soft copies (electronic transmittal) would save time for the patient and provider. In 2007 Congress mandated that DoD and VA electronic medical records be on the same system or that a system be developed that would enable transfer/sharing of records. While a shared electronic system is being developed, it has been installed in only

16 of the 56 VA medical centers and with installation scheduled for the remaining VA centers by the end of 2013.¹ In May 2013, Undersecretary of Defense Frank Kendall said the Defense and Veterans Affairs Departments should be able to create a seamless health records system by the end of the year, and in the meantime the VA will continue using Vista software and DoD will decide between twenty proposals for software.² A public-private partnership could improve this situation by allowing VA volunteers to address that specific software transition to speed the electronic record transition process. It would increase efficiency and save time by having patient care records and historical information available to providers in a more timely fashion.

Ideally, the Primary Care Manager in DoD should be able to connect the wounded warrior and his/her records to the VA system in the area where the wounded warrior is relocating before a wounded warrior separates from the military to prevent a lapse in care. This has already been done in some cases (e.g., Corporal Southern) for the Marines, but it has not been done in other cases (e.g., National Guard wounded warrior). An expanded public-private partnership with the Disabled American Veterans (DAV) that assists veterans in filing their VA claims could work in this instance.

In addition to electronic records, interviews showed some problems with referrals between wounded warrior medical centers. For example, vestibular program patients from Bethesda Naval Hospital to Portsmouth Naval Medical Center were being lost in the system because referrals were expiring and referrals were being entered incorrectly by the doctors and nurses. Wounded warriors have a responsibility in the process but need

¹ Allison A. Hickey, VA Under Secretary for Benefits, "Rising Tide of VA Disability Compensation Claims Prompts Major Transformation," *Echoes Retired Army Newsletter* September-December 2012, 3.

² Jim Garamone, "DOD, VA Move Ahead with Seamless Medical Record Effort," *American Forces Press Service*, May 23, 2013. <http://www.315aw.afrc.af.mil/news/story.asp?id=123349738> (accessed May 31, 2013).

assistance, and referrals must be entered correctly to improve wounded warrior care. For deficient referrals, a refresher course could be provided to care providers to improve skills for writing referrals.

To inform wounded warriors of available resources, the DoD and VA have developed the National Resource Directory website located at <http://www.woundedwarriorresourcecenter.com> and established an e-Benefits portal which the service member can access after leaving the military for questions regarding care.³ The National Resource Directory connects wounded warriors, service members, veterans, their families and caregivers with those who support them. At <http://www.woundedwarriorresourcecenter.com> under the tab for Other Service and Resources, there are tabs for Wounded Warrior Programs, OEF/OIF Veterans, Veteran Service Organizations (chartered and non-chartered), and Volunteer Organizations. Under Volunteer Organizations, the four tabs are Military Appreciation, National Organizations, Community Support Locators, and Non-profit and Charity Evaluators. The author recommends adding a Non-profit organization tab as a fifth tab specific to wounded warrior non-profit organizations to consolidate all the information for wounded warriors in one place. Without this tab, the National Registry Directory/Wounded Warrior Resource Center does not list all the places wounded warriors can go for assistance. The added non-profit organization tab would aid in improving wounded warrior reintegration. State-level programs should also be listed in the National Resource Directory to make the directory more complete.

³ The National Resource Directory is a United States Government inter-agency web portal for Wounded Warriors, Service Members, Veterans, their families and caregivers.

As of 2011, all Services have hard copy Wounded Warrior Handbooks, but the Navy did not have one when Jay Redman was injured in 2007 so his wife and caregiver Erica made her own notebook. As of 2011, there is an electronic DoD Compensation and Benefits Handbook for Wounded, Ill and Injured Service Members online at www.dodlive.mil which lists resources available to help them with care, lodging and what it takes to qualify for that resource's aid. All wounded warriors, whether Active Component or Reserve Component, should be provided a hard copy handbook and information on the existence and resources available at the Wounded Warrior Resource Center's website. In twelve interviews of wounded warriors and caregivers conducted, ten of them had heard of the website, but two had not (those two also suffer from TBI).

A national information campaign on raising awareness of the sacrifice made by the wounded warriors would raise society's awareness of the wounded warriors and their sacrifice on behalf of U.S. citizens for every citizen's freedom. A public-private partnership with non-profit organizations or philanthropic organizations could assist in this effort. If society does not take care of our wounded warriors/wounded veterans and their families, the all-volunteer force will be difficult to maintain. An all-volunteer force must be maintained because "freedom is never more than one generation away from extinction."⁴

Non-profit organization integration with federal and national assets would assist in taking care of wounded warriors. Develop a "standards of care" timeline or accession board for surgeries. If the DoD or VA cannot meet that timeline, that is where the public-

⁴ Bangor Daily News, '*Freedom is ever more than one generation away from extinction*', February 13, 1976, 13. <http://news.google.com/newspapers?nid=2457&dat=19760216&id=BAI1AAAAIBAJ&sjid=VU8KAAAAIBAJ&pg=1897,91069> (accessed May 22, 2013). Author note: Ronald Reagan, pre-presidency, in his address to the annual meeting of the Phoenix Chamber of Commerce.

private partnership can assist. Donations from individuals or non-profit organizations could cover what TRICARE does not to ensure wounded warriors/veterans receive care on time by the right type of doctor to prevent surgery from having to be redone (recall the example of Jay Redman's nose being rebuilt by an oral maxillofacial surgeon whose specialty is rebuilding jaws).

Another idea, based on Jay Redman's interview, is that there are doctors who are willing to provide care to wounded warriors in areas in which DoD does not have the necessary specialists. To provide free consultations to wounded warriors, the DoD or VA could maintain a registry of those doctors, and this information could be provided to the patient by the USSOCOM Care Coalition Advocate, Nurse Case Manager, Wounded Warrior Advocate or Recovery Care Coordinator or their care providers, depending on the Service.

A medical training objective to ensure wounded warriors continue to survive severe wounds is to continue improvements made at the point of injury care and continue to assist service members with as realistic training as possible. One way used is live tissue training done by Army units for non-medics. The example to show for this is the impact "pre-deployment live tissue training had for Paratroopers for the 4th Squadron, 73rd Cavalry Regiment (Airborne) during an eight month deployment to Maiwand and Zharay Districts of Afghanistan," and "the 46 traumatic injuries that the squadron had a hand in treating or evacuating during the first 115 days of the deployment was initially cared for by non-medics."⁵ Just training medics in the Army or Corpsmen in the Navy is not the solution. Buddy care (care provided by a battle buddy or squad member) is

⁵ Louis H. Smith IV, MS, "An Argument for Non-Medic Combat Arms Soldiers Conducting Live Tissue Training as a Pre-Deployment Requirement," *Small Wars Journal*, August 22, 201, 1-2.

provided first until the medic arrives on scene. Army medics are more spread out than in other Services. In the 46 injuries that occurred within the 73rd Cavalry Regiment (Airborne), someone other than a medic was the first to the scene to provide buddy care.

In addition to Service buddy-care training, developing medical internships to assist in wounded warrior care at the in the medical centers of 130 universities which have partnered with DoD in the Joining Force initiative would increase the continuum of care and communication between medical centers. From the Center for Intrepid public-private partnership example given, where “a hub-and-spoke model to channel the latest patient data up to research hubs and push down treatment models to the doctors and therapists,”⁶ recommend using patient data and pushing it to universities who have a public-private partnership with DoD for research and to develop treatment models. An intern program could allow interns, like the ones who helped in one of Jay Redman’s surgeries, to aid in communication between medical centers for certain types of injuries and improve the continuum of care for wounded warriors.

Expanding from the university and non-profit organization model discussed in the thesis, recommend research to pursue a public-public partnership between DoD and private sector businesses such as Du Pont and 3M. Du Pont develops prosthetics, synthetic pigments and creates plastics used in making prosthetics. 3M develops medical products to prevent infection and to treat wounds, medical devices (tape, silicon adhesives) and health information systems such as software for transcription, clinical documentation improvement, document management, and speech recognition. Both of these companies’ products are used in wounded warrior care, and a public-private

⁶ Kristin M. Hall, “Building The Best For Injured Soldiers: Nonprofit’s medical clinics focus on brain injuries, PTSD,” *Washington Post*, August 22, 2012, 1.

partnership between Military Treatment Facilities (MTFs) or Intrepid Centers near the companies for wounded warriors could improve wounded warrior care. Recommend approaching other companies that provide health products to wounded warrior MTFs to see if they would be willing to enter a public-private partnership for care or services with the benefit of a tax deduction. A public-private partnership would aid in availability of prosthetics and replacements when needed.

Each of the Services should adopt a framework similar to the USSOCOM Care Coalition model and the Wounded Warrior Regiment models to provide the wounded warrior a care liaison from the point of injury for life in order to improve the continuum of wounded warrior care. The Marine Wounded Warrior Regiments, Battalions and Detachments have Recovery Care Coordinators (RCC) that aid Marines to return to active duty, or through District Injured Support Coordinators (DISC), to their transition. The Army and Air Force Wounded Warriors have Army or Air Force Wounded Warrior (AW2) Program Advocates while the individual is still serving, and the Navy uses the Navy Safe Harbor Non-Medical Care Manager (NMCM) for non-medical care. While the Services have care models similar to that of the USSOCOM Care Coalition model and the Marine Wounded Warrior Regiment, one person does not support wounded warriors through the entire process in the other Services, hampering the continuum of care.

Keeping faith with wounded warriors also means keeping faith with their caregivers. In addition to the RAND Corporation study grant on the burden on caregivers, the Elizabeth Dole Foundation is providing grants to “the National Military Family Association to develop caregiver best practices, the Military Officers Association

of America to assist in providing legal and financial planning assistance to these families, and the Military Child Education Coalition to address the needs of their children.”⁷

Recommend those studies be reviewed to see where public-private partnerships could assist wounded warrior caregivers as well.

Better care equals better quality of life. The burden on society for the cost of care can be lowered by a public-private partnership. There are burdens on the individual wounded warriors and their families such as the examples of children suffering separation anxiety due to their wounded warrior parents being away for surgeries and wounded warriors having to move closer to their home of record to have their extended families aid spouses in caring for them and their children. Further study for caregivers would provide ways to decrease the toll on them.

Better care would make a difference in separation or retention in service. A Marine chose to separate from the Service when an amputated limb got infected due to his treatment center not having enough prosthetic adjusters on staff for adjustments leading to further amputation of the limb. Having an amputee adjuster to conduct prosthetic adjustments would have saved a Marine another surgery. More prosthetic adjusters are needed, as well as care providers. More care providers would lessen the burden on existing care providers. More care providers are necessary for treating TBI and PTSD. Due to budget constraints and sequestration, it is imperative to establish public-private partnerships to treat TBI and PTSD to increase wounded warrior care and reintegration.

⁷ Gregg Zoroya, “Study: Huge Burden on Caregivers of Military Wounded,” USA Today.com, March 6, 2013, 2.

A public-private partnership with non-profit organizations, such as the Boot Campaign and Wounded Wear, which raise awareness for wounded warrior reintegration in society, already aid in alleviating the consequential costs to society of PTSD by aiding wounded warriors suffering from PTSD and empowering them to get help if needed. A public-private partnership could also assist in decreasing suicide rates. In addition to Wounded Wear and the Boot Campaign, other non-profit organizations aid in raising awareness and performing functions for wounded warriors. Emulating a state-level program such as the Virginia Wounded Warrior Program and expanding it to other states could aid wounded warriors in bridging the gap between what DoD and the VA can fill by coordinating with non-profit organizations.

CHAPTER 6: CONCLUSION

Largely because of the advances in military medicine, the percentage of combat casualties surviving with life changing injuries is greater today than any other war in American history. Since September 11, 2001, the United States has sustained 50,806 wounded warriors, 266,810 with TBI, and 800,000 with PTSD. Although government documents, including the National Security Strategy, dictate the importance of veterans programs to treat and support wounded warriors, this thesis shows there are ways that wounded warrior care and reintegration can be improved.

The crux of the problem is society is unable to fill the gap between the military-government care and long-term care needs of combat wounded. The solution is a public-private partnership that provides long-term care and support. This approach to solve specialty care shortages, lack of trained care professionals for especially for TBI, PTSD, continuum of care coordination, disability rating disparity and transition reflects society's obligation to veterans. There is an obligation for society to take care of its own (moral conscience) and a public-private partnership is needed to provide the assistance for wounded warriors that the government is unable to provide in specialty care type situations. This partnership can sustain funding, support reintegration, and raise awareness. A public-private partnership also has the benefit of bringing society closer to those who serve. It is a societal responsibility and moral imperative because the United States has an all-volunteer force. We are obligated as a nation to support the wounded veterans according to the National Security Strategy. This is the reason private-public partnership for care and reintegration is required and why it is an issue for society. Not

caring for wounded warriors and veterans will negatively impact those considering military service.

The cost of freedom and war is high. The cost of war is not just in treasure from the American taxpayer, but also in blood of the American soldier, sailor, airmen and marine and the “cost in human lives,”¹ which is not just lives lost, but lives damaged. What is certain is that “the consequential costs are born by the civilian population.”² This was true in pre-industrial warfare and remains in modern warfare, and why it is an issue for society today.

Public-private partnership broadens public perspective of the costs of war; not just financial costs, but also the social, moral, psychological costs of war, and what can be done about them. The Army has many units that served in combat for fifteen months (some for longer) at very low levels such as company and platoon. The type of fighting environment at that level led not only to increases in PTSD, but also outright fatalities due to a soldier’s inability to maintain a keen fighting attitude over such long periods. Marine units below the Regional Combat Team Headquarters served seven month tours versus thirteen for the headquarters unit as a means of using unit rotation to alleviate exposure to traumatic events of battle. Shorter unit rotation cycles were beneficial in the Marines case for it being less time versus the fifteen months of the Army. The men of the Fort Carson “Wounded Platoon” served two tours totaling 26 of 39 months in Iraq.

Iraq and Afghanistan are not the first wars in which psychiatric care has been needed for returning veterans. Psychiatric care after World War I cost the United States

¹ Douglas B. Bamforth, “Indigenous People, Indigenous Violence: Pre-contact Warfare on the North American Great Plains,” *Man*, New Series, Vol. 29, No. 1 (March 1994), 112.

² John Landers, “The Destructiveness of Pre-Industrial Warfare: Political and Technological Determinants,” *Journal of Peace Research*, Vol. 42, No. 4 Special Issue on the Demography of Conflict and Violence (July 2005), 465.

over \$1 billion and four million people served for a year and a half. OEF and OIF have been going on over 11 years and the cost has yet to be seen. “Since the Sept. 11, 2001, terrorist attacks on the World Trade Center, 2,333,972 American military personnel have been deployed to Iraq, Afghanistan or both, as of Aug. 30, 2011. Of that total, 1,353,627 have since left the military and 711,986 have used VA health care between fiscal year 2002 and the third-quarter fiscal year 2011.”³ The Army and the Marine Corps are also focused on treating and early identification of the symptoms of PTSD and TBI.⁴

The biggest thing that we can do as a nation be it through the nation, be it through non-profits, DoD, or the VA is for the wounded warriors have to have a purpose. They’ve got to know now that I’ve made it, where do I go from here? Why do I move forward? Why do I continue to function? We went from the military mission focus of we’re going to take that hill, we are going to take that target and all the training is focused on that. You need to know what you want to get your bachelors degree in and then you’ll be the CEO of this company as an example. It’s one of the things I want to do later with Wounded Wear, to custom tailor these things around these guys, to have a passionate purpose tailored to them. You can’t tell the guy with skills to be a leader to be a mechanic. If he doesn’t have a purpose, to feel like his sacrifice was worth it, that other people acknowledge it then to put it succinctly, the purpose is for those guys and gals is to accomplish their American dream because they paid for it more than anybody else in this country.⁵

Lieutenant Redman’s above view of wounded warriors needing a purpose was also discussed by Corporal Southern, the Marine wounded warrior, and the Army and AF wounded warriors. Each wounded warrior stated they needed to find a purpose in life and discover what they are good at post-war injuries in order to successfully reintegrate into society.

³ Luis Martinez and Amy Bingham, “U.S. Veterans: By the Numbers,” *ABC World News with Diane Sawyer*, November 11, 2011, 2.

⁴ Amos, General James F. *The Posture of the United States Marine Corps*. U.S. Government Printing Office, 2012, 5, 21-24.

⁵ Jason Redman, interview by author, Chesapeake, VA, November 18, 2012.

From a care perspective, if an individual is not getting the care they need, they need to know where to go to find, request, and obtain it without having to write a member of Congress to make it happen.⁶ As it stands now, some wounded warriors do not know the information is available or it is not readily accessible to them or even to commanders of wounded warriors who want to improve the situation. This has been solved in the state of Virginia by the Virginia Wounded Warrior Program which bridges the gap between DoD and non-profit organizations to put wounded warriors in touch with the appropriate organization to meet their needs.

University public-private partnerships, philanthropic organization partnerships such as the Intrepid Center and non-profit organizations partnerships would improve care as well. Combat medics, battlefield surgeons, doctors and nurses at various care facilities go above and beyond to save service members, but some of their wounds are so shocking that American society stares at or makes fun of wounded warriors that in some cases has resulted in suicide. Awareness needs to be raised to make wounded warrior reintegration easier, to ensure that wounded warriors do not become cut off from American society, and to decrease the consequential costs to society of PTSD. As illustrated in Chapter 2 by the VA Vocational Rehabilitation and Employment Program of Independent Living services GAO review of 182 cases of fiscal year 2008, the treatment cost was \$6,000 per veteran for a total of \$14 million for Vietnam era veterans who sought care for PTSD in their 50s-60s. At 50,806 wounded warriors up to potentially 800,000 with PTSD that are not currently seeking treatment, \$14 million (\$6,000 for 182 Vietnam era veterans) is the tip of the iceberg of consequential costs for the country thirty years after 9/11. The long-

⁶ Interview Army National Guard Wounded Warrior Caregiver, interview by author, Norfolk, VA, December 26, 2012.

term burden of not filling the gap between the VA and military care and reintegration falls on society. There is a moral imperative to capture costs and develop approaches to address the care and reintegration problem now. There is a Mount Everest coming in consequential costs to society, so the sooner this partnership develops, the better and the nation can avoid a crisis in twenty to thirty years when barriers to care exist now that will go away once at retirement age. The public-private partnership with non-profit organizations will improve wounded warrior reintegration keeping faith with the service member and family.

Freedom is not free. Wounded warriors and American veterans have paid for it in blood, sweat and tears. Wounded warrior care and reintegration must be improved to deter the effects of PTSD and TBI, to eliminate consequential costs to society, to honor wounded warriors' sacrifices, and so that the hard work of combat medics and battlefield surgeons to save a life was not done in vain.

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